AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2013

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CPT 2013 RUC Recommendations

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0300XT	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG6	Apr12	12	ACC, STS	40.00	40.00		
15740	090	R	Feb12	07	Island Pedicle Flap		Editorial						
20665	010	R	Feb12	03	Qualified Healthcare Professional		Editorial						
22522	ZZZ	R	Oct11	EC-N	Percutaneous Vertebroplasty		Editorial						
22586	090	N	Feb12	80	Presacral Lumbar Interbody Fusion	Z1	Apr12	06					No Recommendation
23331	090	F	Oct11	08	Shoulder Arthroplasty	E1	Apr12	04	ASSH, AAOS				Referral to CPT Editorial Panel
23332	090	F	Oct11	08	Shoulder Arthroplasty	E2	Apr12	04	ASSH, AAOS				Referral to CPT Editorial Panel
23472	090	F	Oct11	08	Shoulder Arthroplasty	E3	Apr12	04	ASSH, AAOS	22.13	22.13		
23473	090	N	Oct11	08	Shoulder Arthroplasty	E4	Apr12	04	ASSH, AAOS	25.00	25.00		
23474	090	N	Oct11	08	Shoulder Arthroplasty	E5	Apr12	04	ASSH, AAOS	27.21	27.21		
24160	090	R	Oct11	09	Elbow Arthroplasty and Implant Removal	F1	Apr12	05	ASSH, AAOS				Referral to CPT Editorial Panel
24363	090	R	Oct11	09	Elbow Arthroplasty and Implant Removal	F2	Apr12	05	ASSH, AAOS	22.00	22.00		
24370	090	N	Oct11	09	Elbow Arthroplasty and Implant Removal	F3	Apr12	05	ASSH, AAOS	23.55	23.55		
24371	090	N	Oct11	09	Elbow Arthroplasty and Implant Removal	F4	Apr12	05	ASSH, AAOS	27.50	27.50		
28890	090	R	Feb12	03	Qualified Healthcare Professional		Editorial						
29590	000	R	Feb12	08	Denis-Browne Splint Revision	FF1	Apr12	07	AAOS				
31647	000	N	Oct11	43	Bronchial Valve Procedures	G1	Jan12	06	ACCP, ATS	4.40	4.40		
31648	000	N	Oct11	43	Bronchial Valve Procedures	G2	Jan12	06	ACCP, ATS	4.20	4.20		
31649	ZZZ	N	Oct11	43	Bronchial Valve Procedures	G3	Jan12	06	ACCP, ATS	2.00	2.00		
31651	ZZZ	N	Feb12	EC-H	Bronchial Valve Procedures	G4	Apr12	09	ACCP, ATS	1.58	1.58		
31656	000	D	Feb12	22	Bronchography		Deleted						
31660	000	N	Feb12	85	Bronchial Thermoplasty	AA1	Apr12	08	ACCP, ATS	4.50	4.50		
31661	000	N	Feb12	85	Bronchial Thermoplasty	AA2	Apr12	08	ACCP, ATS	5.00	5.00		
31715	000	D	Feb12	22	Bronchography		Deleted						

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32420	000	D	Feb12	10	Chest Tube Interventions		Apr12	11	ACCP, ATS, ACR				
32421	000	D	Feb12	10	Chest Tube Interventions		Apr12	11	ACCP, ATS, ACR				
32422	000	D	Feb12	10	Chest Tube Interventions		Apr12	11	ACCP, ATS, ACR				
32551	000	R	Feb12	09	Chest Tube Thoracostomy	CC1	Apr12	10	ACS, STS, SCCM	3.50	3.50		
32554	000	N	Feb12	10	Chest Tube Interventions	DD1	Apr12	11	ACCP, ATS, ACR	1.83	1.54		RUC Review October 2012
32555	000	N	Feb12	10	Chest Tube Interventions	DD2	Apr12	11	ACCP, ATS, ACR	2.40	2.21		RUC Review October 2012
32556	000	N	Feb12	10	Chest Tube Interventions	DD3	Apr12	11	ACCP, ATS, ACR	2.50	2.19		RUC Review October 2012
32557	000	N	Feb12	10	Chest Tube Interventions	DD4	Apr12	11	ACCP, ATS, ACR	3.37	3.35		RUC Review October 2012
32701	000	N	Oct11	10	Stereotactic Body Radiation	H1	Jan12	07	STS	5.83	4.18		
33225	ZZZ	R	Feb12	EC-H	Pacemaker or Pacing Cardioverter Defibrillator		Editorial						
33361	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG1	Apr12	12	ACC, STS	29.50	29.50		
33362	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG2	Apr12	12	ACC, STS	32.00	32.00		
33363	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG3	Apr12	12	ACC, STS	33.00	33.00		
33364	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG4	Apr12	12	ACC, STS	34.87	34.87		
33365	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG5	Apr12	12	ACC, STS	37.50	37.50		
33367	ZZZ	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG7	Apr12	12	ACC, STS	11.88	11.88		
33368	ZZZ	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG8	Apr12	12	ACC, STS	14.39	14.39		
33369	ZZZ	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG9	Apr12	12	ACC, STS	19.00	19.00		
33990	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH1	Apr12	13	ACC	12.00	8.15		
33991	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH2	Apr12	13	ACC	16.63	11.88		
33992	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH3	Apr12	13	ACC	6.44	4.00		
33993	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH4	Apr12	13	ACC	6.00	4.17		
36010	XXX	R	Oct11	EC-P	Vascular Injection Procedures		Appendix G						

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
36140	XXX	R	Oct11	EC-P	Vascular Injection Procedures		Appendix G						
36221	000	N	Feb12	12	Cervicocerebal Angiography	S1	Apr12	14	ACC, SIR, AAN, AANS,	4.51	4.51		
36222	000	N	Feb12	12	Cervicocerebal Angiography	S2	Apr12	14	ACC, SIR, AAN, AANS,	6.00	6.00		
36223	000	N	Feb12	12	Cervicocerebal Angiography	S3	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	6.50	6.50		
36224	000	N	Feb12	12	Cervicocerebal Angiography	S4	Apr12	14	ACC, SIR, AAN, AANS,	7.55	7.55		
36225	000	N	Feb12	12	Cervicocerebal Angiography	S5	Apr12	14	ACC, SIR, AAN, AANS,	6.50	6.50		
36226	000	N	Feb12	12	Cervicocerebal Angiography	S6	Apr12	14	ACC, SIR, AAN, AANS,	7.55	7.55		
36227	ZZZ	N	Feb12	12	Cervicocerebal Angiography	S7	Apr12	14	ACC, SIR, AAN, AANS,	2.32	2.32		
36228	ZZZ	N	Feb12	12	Cervicocerebal Angiography	S8	Apr12	14	ACC, SIR, AAN, AANS,	4.25	4.25		
37197	000	N	Jun11	06	Transcath Retrieval Intravascular Foreign Body	A1	Sep11	07	SVS, SIR, ACR	8.00	6.72		
37201	000	D	Oct11	18	Bundle Thrombolysis		Jan12	08	ACR, SIR, SVS				
37203	000	D	Jun11	06	Transcath Retrival Intervascualar Foreign Body		Sep11	07	SVS, SIR, ACR				
37209	000	D	Oct11	18	Bundle Thrombolysis		Jan12	08	ACR, SIR, SVS				
37211	000	N	Oct11	18	Bundle Thrombolysis	I1	Jan12	08	ACR, SIR, SVS	8.00	8.00		
37212	000	N	Oct11	18	Bundle Thrombolysis	I2	Jan12	08	ACR, SIR, SVS	7.06	7.06		
37213	000	N	Oct11	18	Bundle Thrombolysis	I3	Jan12	08	ACR, SIR, SVS	5.00	5.00		
37214	000	N	Oct11	18	Bundle Thrombolysis	I4	Jan12	08	ACR, SIR, SVS	3.04	3.04		
38240	XXX	R	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J1	Apr12	16	ASBMT	4.00	4.00		
38241	XXX	R	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J2	Apr12	16	ASBMT	3.00	3.00		
38242	XXX	R	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J4	Apr12	16	ASBMT	2.11	2.11		
38243	XXX	N	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J3	Apr12	16	ASBMT	2.13	2.13		
43206	000	N	Feb12	23	Optical Endomicroscopy	NN2	Apr12	17	AGA, ASGE, CAP				RUC Recommends Carrier Price

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43234	000	D	Feb12	11	Upper Gastrointestinal Endoscopy		Deleted						
43252	000	N	Feb12	23	Optical Endomicroscopy	NN18	Apr12	17	AGA, ASGE, CAP				RUC Recommends Carrier Price
44705	XXX	N	Feb12	24	Fecal Bacteriotherapy	X1	Apr12	18	IDSA, AGA, ASGE	1.42	1.42		
52287	000	N	Feb12	26	Bladder Chemodenervation	JJ1	Apr12	19	AUA	3.74	3.02		RUC Review October 2012
59300	000	R	Feb12	03	Other Qualified Healthcare Provider		Editorial						
64561	010	R	Oct11	EC-M	Neurostimulator Code Revisions		Editorial						
64612	010	R	Feb12	06	Chemodenervation for Chronic Migraine	DD1	Apr12	20	HNS, AAN, AAO	1.41	1.41		
64613	010	F	Feb12	06	Chemodenervation for Chronic Migraine	DD2	Apr12	20	HNS, AAN, AAO				Referral to CPT Editorial Panel
64614	010	R	Feb12	06	Chemodenervation for Chronic Migraine	DD3	Apr12	20	HNS, AAN, AAO				RUC Review October 2012
64615	010	N	Feb12	06	Chemodenervation for Chronic Migraine	DD4	Apr12	20	HNS, AAN, AAO	1.85	1.85		
65800	000	R	Oct11	19	Paracentesis of the Eye	K1	Apr12	21	AAO	1.53	1.53		
65805	000	D	Feb12	19	Paracentesis of the Eye		Apr12	21	AAO				
67810	000	R	Jun11	08	Biopsy of Eyelid	B1	Sep11	08	AAO, AAD	1.18	1.18		
71040	XXX	D	Feb12	22	Bronchography		Deleted						
71060	XXX	D	Feb12	22	Bronchography		Deleted						
72040	XXX	R	Oct11	17	X-Ray of Cervical Spine	L1	Jan12	09	ACR, ASNR	0.22	0.22	Yes	
72050	XXX	R	Oct11	17	X-Ray of Cervical Spine	L2	Jan12	09	ACR, ASNR	0.31	0.31	Yes	
72052	XXX	R	Oct11	17	X-Ray of Cervical Spine	L3	Jan12	09	ACR, ASNR	0.36	0.36	Yes	
75650	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75660	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75662	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75665	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				

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75671	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75676	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75680	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75685	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ACC, SIR, AAN, AANS,				
75896	XXX	R	Oct11	18	Bundle Thrombolysis	I5	Jan12	08	ACR, SIR, SVS				2012, RUC recommends Carrier
75898	XXX	R	Oct11	18	Bundle Thrombolysis	I6	Jan12	08	ACR, SIR, SVS				2012, RUC recommends Carrier
75900	XXX	D	Oct11	18	Bundle Thrombolysis		Jan12	08	ACR, SIR, SVS				
75961	XXX	D	Jun11	06	Bundle Thrombolysis		Apr12	15	SIR, SVS				
76000	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
76001	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
76376	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
76885	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
76886	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
77071	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
78000	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78001	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78003	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78006	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78007	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78010	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78011	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				
78012	XXX	N	Feb12	13	Thyroid Uptake/Imaging	T1	Apr12	22	SNM, ACNM, ACR	0.19	0.19		

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78013	XXX	N	Feb12	13	Thyroid Uptake/Imaging	T2	Apr12	22	SNM, ACNM, ACR	0.37	0.37		
78014	XXX	N	Feb12	13	Thyroid Uptake/Imaging	T3	Apr12	22	SNM, ACNM, ACR	0.50	0.50		
78070	XXX	R	Feb12	14	Parathyroid Imaging	U1	Apr12	23	SNM, ACNM, ACR	0.80	0.80		
78071	XXX	N	Feb12	14	Parathyroid Imaging	U2	Apr12	23	SNM, ACNM, ACR	1.20	1.20		
78072	XXX	N	Feb12	14	Parathyroid Imaging	U3	Apr12	23	SNM, ACNM, ACR	1.60	1.60		
81201	XXX	N	Feb12	29	Molecular Pathology-Adenomatous Polyposis Coli	V1	Apr12	24	CAP	1.40	1.40		
81202	XXX	N	Feb12	29	Molecular Pathology-Adenomatous Polyposis Coli	V2	Apr12	24	CAP	0.52	0.52		
81203	XXX	N	Feb12	29	Molecular Pathology-Adenomatous Polyposis Coli	V3	Apr12	24	CAP	0.80	0.80		
81235	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C1	Sep11	09	CAP	0.51	0.51		
81252	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C2	Sep11	09	CAP	0.65	0.65		
81253	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C3	Sep11	09	CAP	0.52	0.52		
81254	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C4	Sep11	09	CAP	0.40	0.40		
81321	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C5	Sep11	09	CAP	0.80	0.80		
81322	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C6	Sep11	09	CAP	0.52	0.52		
81323	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C7	Sep11	09	CAP	0.65	0.65		
81400	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81401	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81402	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81403	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81404	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81405	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81406	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						

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81407	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81408	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						
81500	XXX	N	Feb12	34	Ovarian Malignancy		CLFS						Performed by Physicians at this Time
81503	XXX	N	Feb12	35	OVA1 Biomarkers Gynecological Malignancy		CLFS						Performed by Physicians at this Time
81506	XXX	N	Feb12	36	Diabetes Pre-diagnostic Risk Screen		CLFS						Performed by Physicians at this Time
81509	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						Performed by Physicians at this Time
81510	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						Performed by Physicians at this Time
81511	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						Performed by Physicians at this Time
81512	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						Performed by Physicians at this Time
81599	XXX	N	Feb12	33	Molecular Pathology-Multianalyte Assays		CLFS						RUC Recommending Carrier Price
82009	XXX	R	Jun11	11	Beta-Hydroxybutyrate Assay, Quantitative Blood		CLFS						Performed by Physicians at this Time
82010	XXX	R	Jun11	11	Beta-Hydroxybutyrate Assay, Quantitative Blood		CLFS						Performed by Physicians at this Time
82777	XXX	N	Oct11	26	Galectin-3 Assay		CLFS						Performed by Physicians at this Time
83890	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83891	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83892	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83893	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83894	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83896	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83897	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83898	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
83900	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83901	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83902	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83903	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83904	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83905	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83906	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83907	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83908	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83909	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83912	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83913	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
83914	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
86148	XXX	R	Feb12	82	Cell Enumeration Circulating Tumor Cells		Apr12	Editorial	CAP				
86152	XXX	N	Feb12	82	Cell Enumeration Circulating Tumor Cells		CLFS	25	CAP				Performed by Physicians at this Time

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
86153	XXX	N	Feb12	82	Cell Enumeration Circulating Tumor Cells	W1	Apr12	25	CAP	0.69	0.69		
86711	XXX	N	Feb12	41	Antibody Detection		CLFS						Performed by Physicians at this Time
86828	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Performed by Physicians at this Time
86829	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Performed by Physicians at this Time
86830	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Performed by Physicians at this Time
86831	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Performed by Physicians at this Time
86832	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Performed by Physicians at this Time
86833	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Not Typically Performed by Physicians at this Time
86834	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Not Typically Performed by Physicians at this Time
86835	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						Not Typically Performed by Physicians at this Time
87498	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87521	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87522	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87535	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87536	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87538	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87539	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						Performed by Physicians at this Time
87631	XXX	N	Oct11	28	Respiratory Virus Multiplex Nucleic Acid Assays		CLFS						Not Typically Performed by Physicians at this Time
87632	XXX	N	Oct11	28	Respiratory Virus Multiplex Nucleic Acid Assays		CLFS						Performed by Physicians at this Time

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87633	XXX	N	Oct11	28	Respiratory Virus Multiplex Nucleic Acid Assays		CLFS						Performed by Physicians at this Time
87901	XXX	R	Feb12	44	Viral Drug Resistance Genotyping		CLFS						Performed by Physicians at this Time
87910	XXX	N	Feb12	44	Viral Drug Resistance Genotyping		CLFS						Performed by Physicians at this Time
87912	XXX	N	Feb12	44	Viral Drug Resistance Genotyping		CLFS						Performed by Physicians at this Time
88375	XXX	N	Feb12	23	Optical Endomicroscopy	NN39	Apr12	17	CAP				RUC Recommends Carrier Price
88384	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
88385	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
88386	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						
90460	XXX	R	Jun11	14	Immunization Administration		Vaccine						
90461	ZZZ	R	Jun11	14	Immunization Administration		Vaccine						
90653	XXX	N	Feb12	63	Adjuvanted Influenza Vaccine		Vaccine						
90655	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						
90656	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						
90657	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						
90658	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						
90660	XXX	R	Feb12	62	Intranasal Influenza Virus		Vaccine						
90665	XXX	D	Oct11	30	Lyme Disease Vaccine		Vaccine						
90672	XXX	N	Feb12	62	Intranasal Influenza Virus		Vaccine						
90701	XXX	D	Jun11	15	Whole Cell DTP Vaccine		Vaccine						
90718	XXX	D	Jun11	15	Tetanus and Diphtheria Toxoid		Vaccine						
90739	XXX	N	Feb12	65	Hepatitis B		Vaccine						
90746	XXX	R	Feb12	65	Hepatitis B		Vaccine						

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90785	ZZZ	N	Feb12	93	Psychotherapy	LL1	Apr12	26	AACAP, APA (HCPAC)				RUC Recommends Carrier Price
90791	XXX	N	Feb12	93	Psychotherapy	LL2	Apr12	26	AACAP, APA (HCPAC)	3.00	3.00		
90792	XXX	N	Feb12	93	Psychotherapy	LL3	Apr12	26	AACAP, APA (HCPAC)	3.25	3.25		
90801	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90802	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90804	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90805	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90806	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90807	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90808	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90809	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90810	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90811	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90812	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90813	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90814	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90815	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90816	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90817	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90818	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90819	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90821	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				

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90822	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90823	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90824	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90826	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90827	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90828	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90829	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90832	XXX	N	Feb12	93	Psychotherapy	LL4	Apr12	26	AACAP, APA (HCPAC)	1.50	1.50		
90833	ZZZ	N	Feb12	93	Psychotherapy	LL5	Apr12	26	AACAP, APA (HCPAC)	1.50	1.50		
90834	XXX	N	Feb12	93	Psychotherapy	LL6	Apr12	26	AACAP, APA (HCPAC)	2.00	2.00		
90836	ZZZ	N	Feb12	93	Psychotherapy	LL7	Apr12	26	AACAP, APA (HCPAC)	1.90	1.90		
90837	XXX	N	Feb12	93	Psychotherapy	LL8	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	2.25	3.00		
90838	ZZZ	N	Feb12	93	Psychotherapy	LL9	Apr12	26	AACAP, APA (HCPAC)	2.10	2.50		
90839	XXX	N	Feb12	93	Psychotherapy	LL10	Apr12	26	AACAP, APA (HCPAC)				RUC Recommends Carrier Price
90840	ZZZ	N	Feb12	93	Psychotherapy	LL11	Apr12	26	AACAP, APA (HCPAC)				RUC Recommends Carrier Price
90845	XXX	F	Feb12	93	Psychotherapy	LL12	Apr12	26	AACAP, APA (HCPAC)	0.00	2.10		recommendation from September 2011
90846	XXX	F	Feb12	93	Psychotherapy	LL13	Apr12	26	AACAP, APA (HCPAC)	2.40	2.40		
90847	XXX	F	Feb12	93	Psychotherapy	LL14	Apr12	26	AACAP, APA (HCPAC)	2.50	2.50		
90849	XXX	F	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90853	XXX	R	Feb12	93	Psychotherapy	LL15	Apr12	26	AACAP, APA (HCPAC)	0.59	0.59	Yes	
90857	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				
90862	XXX	D	Feb12	93	Psychotherapy		Apr12	26	AACAP, APA (HCPAC)				

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90875	XXX	R	Feb12	93	Psychotherapy		Apr12	Editorial	AACAP, APA (HCPAC)				
90876	XXX	R	Feb12	93	Psychotherapy		Apr12	Editorial	AACAP, APA (HCPAC)				
90889	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
91110	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
91111	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
91112	XXX	N	Feb12	67	Wireless Motility Capsule	Y1	Apr12	27	AGA, ASGE	2.10	2.10		
92286	XXX	R	Oct11	20	Anterior Segment Imaging	M1	Apr12	28	AAO, AOA	0.40	0.40		
92287	XXX	R	Oct11	20	Anterior Segment Imaging	M2	Apr12	28	AAO, AOA				Referral to CPT Assistant
92920	000	N	Oct11	21	Percutaneous Coronary Intervention	N1	Jan12	10	ACC	9.25	9.00		
92921	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N2	Jan12	10	ACC	4.00	4.00		
92924	000	N	Oct11	21	Percutaneous Coronary Intervention	N3	Jan12	10	ACC	12.00	11.00		
92925	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N4	Jan12	10	ACC	5.00	5.00		
92928	000	N	Oct11	21	Percutaneous Coronary Intervention	N5	Jan12	10	ACC	10.49	10.49		
92929	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N6	Jan12	10	ACC	5.00	4.44		
92933	000	N	Oct11	21	Percutaneous Coronary Intervention	N7	Jan12	10	ACC	14.00	12.32		
92934	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N8	Jan12	10	ACC	5.50	5.50		
92937	000	N	Oct11	21	Percutaneous Coronary Intervention	N9	Jan12	10	ACC	11.00	10.49		
92938	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N10	Jan12	10	ACC	5.00	6.00		
92941	000	N	Oct11	21	Percutaneous Coronary Intervention	N11	Jan12	10	ACC	12.32	12.32		
92943	000	N	Oct11	21	Percutaneous Coronary Intervention	N12	Jan12	10	ACC	12.32	12.32		
92944	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N13	Jan12	10	ACC	6.00	6.00		
92973	ZZZ	R	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				

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92980	000	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				
92981	ZZZ	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				
92982	000	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				
92984	ZZZ	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				
92995	000	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				
92996	ZZZ	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				
93015	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial			0.75	0.75	Yes	
93016	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial		ACC	0.45	0.45	Yes	
93224	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial		ACC				
93227	XXX	R	Feb12	03	Qualified Helathcare Professional		Editorial						
93228	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93229	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93268	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93272	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93279	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93286	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93288	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93293	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93294	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93295	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						

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93297	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93298	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93351	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93651	000	D	Oct11	22	Bundling EPS and Transcatheter Ablation		Jan12	11	ACC, HRS				
93652	000	D	Oct11	22	Bundling EPS and Transcatheter Ablation		Jan12	11	ACC, HRS				
93653	000	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q1	Jan12	11	ACC, HRS	18.00	15.00		
93654	000	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q2	Jan12	11	ACC, HRS	25.00	20.00		
93655	ZZZ	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q3	Jan12	11	ACC, HRS	9.00	9.00		
93656	000	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q4	Jan12	11	ACC, HRS	23.40	20.02		
93657	ZZZ	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q5	Jan12	11	ACC, HRS	10.00	10.00		
93745	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93750	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93790	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
93797	000	R	Feb12	03	Qualified Healthcare Professional		Editorial						
94014	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
94016	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
94452	XXX	R	Feb12	03	Qualified Healhtcare Professional		Editorial						
94610	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
94774	YYY	R	Feb12	03	Qualified Healthcare Professional		Editorial						
94777	YYY	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95004	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95010	XXX	R	Feb12	15	Percutaneous Allergy Testing		Apr12	29	JCAAI				

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95015	XXX	R	Feb12	15	Percutaneous Allergy Testing		Apr12	29	JCAAI				
95017	XXX	N	Feb12	15	Percutaneous Allergy Testing	EE1	Apr12	29	JCAAI				
95024	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95027	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95075	ZZZ	D	Feb12	71	Allergen Ingestion Challenge Test		Apr12	30	JCAAI				
95076	XXX	N	Feb12	71	Allergen Ingestion Challenge Test	MM1	Apr12	30	JCAAI	1.50	1.50		
95079	XXX	N	Feb12	71	Allergen Ingestion Challenge Test	MM2	Apr12	30	JCAAI	1.38	1.38		
95018	XXX	N	Feb12	15	Percutaneous Allergy Testing	EE2	Apr12	29	JCAAI				
95120	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95782	XXX	N	Feb12	73	Pediatric Polysomnography	KK1	Apr12	31	ACCP, ATS, AAN	3.00	3.00		
95783	XXX	N	Feb12	73	Pediatric Polysomnography	KK2	Apr12	31	ACCP, ATS, AAN	3.20	3.20		
95808	XXX	R	Feb12	73	Pediatric Polysomnography		Editorial	31	ACCP, ATS, AAN				
95810	XXX	R	Feb12	73	Pediatric Polysomnography		Editorial	31	ACCP, ATS, AAN				
95811	XXX	R	Feb12	73	Pediatric Polysomnography		Editorial	31	ACCP, ATS, AAN				
95830	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95860	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R1	Apr12	32	AAPMR, AAN, APTA, AAN	0.96	0.96	Yes	
95861	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R2	Apr12	32	AAPMR, AAN, APTA, AAN	1.54	1.54	Yes	
95863	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R3	Apr12	32	AAPMR, AAN, APTA, AAN	1.87	1.87	Yes	
95864	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R4	Apr12	32	AAPMR, AAN, APTA, AAN	1.99	1.99	Yes	
95865	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R5	Apr12	32	AAPMR, AAN, APTA, AAN	1.57	1.57	Yes	
95866	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R6	Apr12	32	AAPMR, AAN, APTA, AAN	1.25	1.25	Yes	
95867	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R7	Apr12	32	AAPMR, AAN, APTA, AAN	0.79	0.79	Yes	

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95868	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R8	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.18	1.18	Yes	
95869	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R9	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.37	0.37	Yes	
95870	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R10	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.37	0.37	Yes	
95885	ZZZ	F	Feb12	16	EMG in Conjunction with Nerve Testing	R11	Apr12	32	AAN, AAPMR, AANEM, APTA				Reaffirm RUC recommendation from April 2011 RUC Meeting
95886	ZZZ	F	Feb12	16	EMG in Conjunction with Nerve Testing	R12	Apr12	32	AAN, AAPMR, AANEM, APTA				Reaffirm RUC recommendation from April 2011 RUC Meeting
95887	ZZZ	F	Feb12	16	EMG in Conjunction with Nerve Testing	R13	Apr12	32	AAN, AAPMR, AANEM, APTA				Reaffirm RUC recommendation from April 2011 RUC Meeting
95900	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				
95903	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				
95904	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				
95905	XXX	F	Feb12	16	EMG in Conjunction with Nerve Testing	R21	Apr12	32	AAN, AAPMR, AANEM, APTA				Reaffirm RUC recommendation from October 2009 RUC Meeting
95907	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R14	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.00	1.00		

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95908	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R15	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.68	1.37		
95909	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R16	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	2.28	1.77		
95910	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R17	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	2.90	2.80		
95911	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R18	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	3.44	3.34		
95912	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R19	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	4.10	4.00		
95913	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R20	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	4.30	4.20		
95920	ZZZ	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				
95921	XXX	F	Feb12	17	Autonomic Funtion Testing	BB1	Apr12	33	AANEM, AAN	0.90	0.90	Yes	
95922	XXX	F	Feb12	17	Autonomic Funtion Testing	BB2	Apr12	33	AANEM, AAN	1.10	0.96	Yes	
95923	XXX	F	Feb12	17	Autonomic Funtion Testing	BB4	Apr12	33	AANEM, AAN	0.90	0.90	Yes	
95924	XXX	N	Feb12	17	Autonomic Funtion Testing		Apr12	33	AANEM, ACP, AAN	1.89	1.86		RUC Review October 2012, RUC Recommends Interim Value

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95930	XXX	R	Feb12	77	Vision Screening		Editorial						
95934	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AAPMR, AAN, APTA, AAN				
95936	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AAPMR, AAN, APTA, AAN				
95940	ZZZ	N	Oct11	EC-C	Intraoperative Neurophysiology Monitoring	P1	Apr12	32	AAPMR, AAN, APTA, AAN	0.60	0.60		
95941	ZZZ	N	Oct11	EC-C	Intraoperative Neurophysiology Monitoring	P2	Apr12	32	AAPMR, AAN, APTA, AAN	2.00	2.00		
95943	XXX	N	Feb12	17	Autonomic Funtion Testing	BB5	Apr12	33	AANEM, AAN				RUC Review October 2012
95954	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95961	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95962	ZZZ	R	Feb12	03	Qualified Healthcare Professional		Editorial						
95991	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
96004	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
97530	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
97532	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
97533	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
97535	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
97537	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
97755	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
98969	XXX	R	Oct11	36	Online Medical Evaluation		Editorial						
99000	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99001	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99002	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99070	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
99071	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99078	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99091	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99143	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99148	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99174	XXX	R	Feb12	77	Vision Screening		Editorial						
99183	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						
99234	XXX	R	Feb12	18	Observation or Inpatient Care		Editorial						
99235	XXX	R	Feb12	18	Observation or Inpatient Care		Editorial						
99236	XXX	R	Feb12	18	Observation or Inpatient Care		Editorial						
99444	XXX	R	Oct11	36	Online Medical Evaluation		Editorial						
99486	XXX	N	Oct11	03	Neonatal Pediatric Transport	Q1	Jan12	13	AAP, SCCM	1.30	1.30		
99487	ZZZ	N	Oct11	03	Neonatal Pediatric Transport	Q2	Jan12	13	AAP, SCCM				

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
90863	ZZZ	N	Feb12	93	Psychotherapy	LL16	HCPAC	55	APA, NASW, AACAP, APA (HCPAC)				HCPAC, RUC Recommends Carrier Price

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2013

INTRODUCTORY MATERIALS

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May 30, 2012

Jonathan Blum
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Mr. Blum:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2013*, as well as to existing services identified by the RUC's Relativity Assessment Workgroup and CMS. If implemented, the RUC recommendations should result in a positive adjustment to the Medicare conversion factor.

CPT 2013 New and Revised Codes

Enclosed are two binders containing RUC recommendations, including those for new and revised CPT codes. The total number of coding changes for *CPT 2013* is 375, including 142 additions, 134 revisions, and 99 deletions. In addition, 25 new codes were identified as part of the family for review in relationship to the new/revised codes. The 301 new/revised/related family CPT codes are summarized as follows:

- 39 services are not payable on the RBRVS or do not require physician work at this time (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes.

- One new and revised code was addressed by the RUC HCPAC Review Board and that recommendation is submitted directly by the HCPAC.

- For 2 codes (22586 and 95943), the RUC offers no recommendation at this time. However, for CPT code 95943 the RUC will be offering recommendations to CMS in October 2012.

- The RUC recommends that 9 codes be carrier priced.

- 62 codes were modified editorially to specify "physician or other qualified healthcare professional" and reporting of these codes is not expected to change.

The RUC submits work value and/or practice expense inputs for 188 new/ revised/related family CPT codes.

Nearly seventy-five percent of the CPT code revisions for CPT 2013 originated from the potentially misvalued services process.

Molecular Pathology Services

The RUC appreciates CMS's continued dialogue about the valuation of Molecular Pathology services. The RUC continues to assert that regardless of the Agency's decision to pay for these services under the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule, the relative value units for these services should be published in the Medicare Final Rule to ensure all stakeholders, including private payers, have accurate valuation information for these new services. Therefore, the entire set of Molecular Pathology services with RUC recommendations have been included in this submission. The attached materials include previously submitted Molecular Pathology Tier 1 and 2 RUC recommendations from April 2011 and Tier 1 and 2 RUC recommendations from October 2011. These are included in addition to the RUC recommendations for the Molecular Pathology Tier 1 and Adenomatous Polyposis Coli set of codes reviewed during the CPT 2013 cycle.

Existing Services Identified by RUC and CMS for Review

In addition to the new/revised CPT code submission, the RUC submits recommendations for 62 services identified by the RUC or CMS as potentially misvalued and reviewed at the April 2012 RUC meeting. These recommendations are in addition to the 104 recommendations for existing services submitted to CMS following the RUC's September 2011 and January 2012 meetings.

Revised Multi-Specialty Points of Comparison (MPC) List

The RUC continues to develop processes and methods to improve our recommendations to improve relativity within the RBRVS. One methodological improvement is the increased use of reference services on the RUC's Multi-Specialty Points of Comparison (MPC) List. In August 2010, the RUC's MPC Workgroup began a systematic review and restructuring of the MPC list. The primary objective of this review was to create a MPC list of codes that have been recently RUC reviewed and significantly performed by multiple specialties. The Workgroup defined "significantly performed" as either 10% of a service's total utilization or an absolute number of 10,000 performed by each of one or more specialties.

The Workgroup used four separate stages to determine codes to be on the new cross-specialty MPC list:

1. The Workgroup collected a list of 348 codes reviewed by the RUC since 2000 which have two or more specialties performing the services at a significant level.

2. The Workgroup then addressed two issues related to this initial list of 348 codes. First, there was a lack of codes above 10.00 work RVUs. Second, there was significant redundancy in work values below 2.00. To address these two issues, specialty societies were queried to submit their recommendations on which codes were redundant and could be removed and which of the current MPC codes above 10.00 work RVUs should be put on the new cross-specialty MPC list. This review resulted in a revised list that included 223 services.

3. From this revised list of 223 codes, the members noted a lack of services in the 5.00-10.00 work RVU range. To strengthen this portion of the cross-specialty list, the members looked at all codes reviewed by the RUC since 2007 with at least two specialties performing the service. The Workgroup chose 33 codes to add to the list.

4. Finally, the MPC Workgroup re-examined set of 35 codes that were added to the list in Step 2 due to address the inclusion of higher work RVUs. However these codes were clearly not multi-specialty or billed frequently in Medicare as they were either performed over 95% by one specialty or performed less than 1,000 times. To ensure that the list of codes are truly multi-specialty, the Workgroup deleted the 35 codes.

The resulting list of 221 services was adopted by the RUC in April 2012. This list of codes will enhance the RUC's ability to conduct and analyze inter-specialty comparisons for codes under review. The MPC Workgroup is committed to further refinement of the revised MPC list and will conduct, with specialty society input, a process to review appropriate codes to be added to the list. The RUC appreciates the continued involvement of CMS staff in this lengthy process. We are hopeful that the new MPC list will be useful to CMS in conducting your review of RUC recommendations and during annual refinement panel meetings.

Practice Expense Subcommittee

The attached materials include direct expense input (medical staff, supplies and equipment) recommendations for each code reviewed. As a reminder, cost estimates for medical supplies and equipment not listed on the "CMS labor, Supply, and Equipment List for the Year 2012" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity, or cash discounts, prices for used equipment or any other

factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment.

In addition to recommendations related to the specific CPT codes under review, the PE Subcommittee reviewed a few global issues during this cycle. One issue reviewed was the inputs required to clean and disinfect endoscopes. In January 2012, the Subcommittee noted that the pack included in supplies for cleaning the endoscope, CMS supply item SA042, includes gluteraldehyde (disinfecting/sanitizing agent) and does not contain a basin for the gluteraldehyde. The Practice Expense Subcommittee recommends that the irrigation basin, CMS code SJ009, be added to the endoscope cleaning and disinfecting pack. The recommendation is included in this submission.

The RUC and Practice Expense Subcommittee have concluded that the typical mode for imaging is now digital and, therefore will engage in a process to transition expenses related to film technology to digital technology. A Migration of Radiologic Images from Film to Digital Workgroup will be formed and will develop the appropriate practice expense inputs and process to replace practice expense inputs related to film for the appropriate imaging services. The Workgroup will present their initial recommendations to the Practice Expense Subcommittee at the October 2012 RUC meeting. Background information related to this issue is included in the attached submission.

Enclosed Recommendations and Supporting Materials:

Included in these binders, and on the enclosed CD are:

- RUC Recommendation Status Report for New and Revised Codes

- RUC Recommendation Status Report for more than 1,300 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued. In addition, a spreadsheet containing the codes specific to this submission is included.

- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.

- Physician Time File: A list of the physician time data for each of the CPT codes reviewed at the September 2011, January 2012, and April 2012 RUC meetings. In addition, a new physician time file for all services within the RBRVS is enclosed.

- Pre-Service Time Packages Definitions: The RUC developed physician pre-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service time data for all codes reviewed by the RUC.

- PLI Crosswalk Table: The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.

- Source Code Utilization Crosswalk Table – A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2013 conversion factor increase.

- New Technology List and Flow Chart – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 401 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.

- Revised Multi-Specialty Points of Comparison (MPC) List – The revised MPC list is attached to this submission. For your convenience, the list is provided in both CPT code and RVU order.

- Practice Expense Subcommittee recommendation to add CMS code SJ009 to the endoscope cleaning and disinfecting pack SA042. Background information on the migration of film to digital technology for imaging services is also included.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,



Barbara Levy, MD

Enclosures
cc: Kathy Bryant
Edith Hambrick, MD
Ryan Howe
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Sara Vitolo
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May 26, 2012

Jonathan Blum
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: HCPAC Recommendations

Dear Mr. Blum:

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board submits the enclosed recommendation to the Centers for Medicare and Medicaid Services (CMS). The HCPAC reviewed CPT code 90863 *Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services* identified through the Fourth Five-Year Review process, at its April 26, 2012 meeting.

The RUC and HCPAC are fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values. The HCPAC appreciates the opportunity to provide recommendations related to the 2013 Medicare Physician Payment Schedule. If you have any questions regarding this submission, please contact Susan Clark via (202) 789-7495 or Susan.Clark@ama-assn.org at the AMA for clarification regarding these recommendations.

Sincerely,

Arthur Traugott, MD
HCPAC Chair

Anthony Hamm, DC
HCPAC Co-Chair

cc: HCPAC Participants
Edith Hambrick, MD
Ryan Howe
Christina Ritter
Sara Vitolo

Attachments

The RUC Relativity Assessment Workgroup Progress Report

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

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT code. The Workgroup maintains and develops all standards and procedures associated with the list, which contains 301 services. In September 2010, the re-review cycle began and since then the RUC has recommended 4 services to be re-examined. The remaining services are rarely performed (ie, less than 500 times per year in the Medicare population) and will not be re-examined. The Workgroup will continue to review the remaining 338 services every September after three years of Medicare claims data is available for each service.

Site of Service Anomalies

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

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

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

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

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

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

High Volume Growth

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

The RUC recommended that 23 services be removed from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 16 codes and will review another 10 services in the CPT 2014 cycle. In September 2011, the RUC began review of services after two years of utilization data were collected. The RUC will provide recommendations to CMS for 3 services for the 2013 Medicare Physician Payment Schedule and for 1 service for the 2014 Medicare Physician Payment Schedule, and will continue to review the remaining 6 services after additional utilization data is collected.

CMS Fastest Growing

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

The RUC recommended that 49 services be removed from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 24 codes and will review another 3 services in the CPT 2014 cycle. The RUC will submit 21 recommendations to CMS for the 2013 Medicare Physician Payment Schedule and review 14 services after additional utilization data is available.

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

Services Surveyed by One Specialty – Now Performed by A Different Specialty
Services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT. To date, the CPT Editorial Panel has deleted 18 codes and will review 1 codes in the CPT 2014 cycle. The RUC submitted 21 recommendations for physician work and practice expense to CMS for the 2011-2013 Medicare Physician Payment Schedules.

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

Utilization over 100,000
The RUC continued to review Harvard-only valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services and the RUC expanded by the screen by 101 codes to include the family of services, totaling 139 services. The CPT Editorial Panel deleted 26 codes and will review 1 services in the CPT 2014 cycle. The RUC submitted 109 recommendations to CMS for the 2011-2013 Medicare Physician Payment Schedules. The RUC will review 4 codes in October 2012.

Utilization over 30,000
In April 2011, the RUC continued to identify Harvard-only valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 64 services. The CPT Editorial Panel deleted 11 codes and will review 6 services in the 2014 cycle. The RUC will submit recommendations for 39 services for the 2013 Medicare Physician Payment Schedule and will review 8 services in the 2014 cycle.

Bundled CPT Services

Reported 95% or More Together

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

Reported 75% or More Together

In February 2010, the Workgroup continued review of services provided on the same day by the same provider at a lower threshold. The Workgroup analyzed code pairs provided on the same day by the same physician. The Relativity Assessment Workgroup reviewed the Medicare claims data for these services and found 151 relevant code pairs. These codes were divided into similar "groups" and the 20 code groups, totaling 80 codes with the highest allowed charges were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. The RUC added 72 additional codes as part of the family of services, totaling 152 services. The CPT Editorial Panel deleted 26 codes and will consider 7 of codes in the CPT 2014 cycle. The RUC reviewed the work and practice expense and submitted recommendations to CMS for 110 services to account for efficiencies when performed together, for the 2011-2013 Medicare Physician Payment Schedules. The RUC will submit recommendations for 9 services for the 2014 Medicare Physician Payment Schedule.

Low Value/Billed in Multiple Units

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

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

Low Value/High Volume Codes

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

Medicare Physician Payment Schedule and 5 recommendations to CMS for the 2013 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Multi-Specialty Points of Comparison List
CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data and as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 158 services to include an additional codes as part of a family (105 codes of which are part of the review of GI endoscopy codes). The CPT Editorial Panel deleted 8 codes and will review 1 code for revision. The RUC submitted recommendations for 39 codes for the 2012 and 2013 Medicare Physician Payment Schedules and will review the remaining 110 codes in the 2014 and 2015 cycles.

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

The RUC reviewed the 70 services identified and expanded the list to 117 services to include additional codes as part of the family. The CPT Editorial Panel deleted 7 codes and will review 9 codes for the 2014 cycle. The RUC will submit 47 recommendations to CMS for the 2013 Medicare Physician Payment Schedule and will submit the remaining recommendations for the 2014 Medicare Physician Payment Schedule.

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

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

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**1,329**
Codes Completed	**1083**
Work and PE Maintained	348
Work Increased	89
Work Decreased*	357
Direct Practice Expense Revised (beyond work changes)*	121
Deleted from CPT	168
Codes Under Review	**246**
Referred to CPT	46
RUC to Review October 2012	60
Future Review or Re-review	140

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

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

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

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	High IWPUT	MPC List	CMS Request - PE Review	Harvard Valued - Utilization over 30,000	Harvard Valued - Utilization over 100,000	CMS Request - NPRM for 2012	CMS High Expediture Procedural Codes
29590	Denis-Browne splint strapping	Refer to CPT for deletion									X		
32551	Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)	3.50								X			
65800	Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous	1.53								X			
65805	Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous	Deleted from CPT								X			
92286	Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count	0.40								X			
92287	Special anterior segment photography with interpretation and report; with fluorescein angiography	Refer to CPT Asstistant								X			
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	1.40			X	X						X	
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	0.90			X								
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	0.70			X								
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	0.70			X								
47600	Cholecystectomy;	20.00										X	
47605	Cholecystectomy; with cholangiography	21.00										X	
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	3.00										X	

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	High IWPUT	MPC List	CMS Request - PE Review	Harvard Valued - Utilization over 30,000	Harvard Valued - Utilization over 100,000	CMS Request - NPRM for 2012	CMS High Expediture Procedural Codes
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	3.50										X	
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	3.23	X									X	
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	4.00	X									X	
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	1.44	X									X	
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	3.73								X		X	
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	4.78										X	
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)	2.19										X	
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	Refer to CPT for Deletion										X	
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	4.34										X	
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	5.34								X		X	
13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)	1.24										X	
13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)	2.38										X	
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	0.60											X

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	High IWPUT	MPC List	CMS Request - PE Review	Harvard Valued - Utilization over 30,000	Harvard Valued - Utilization over 100,000	CMS Request - NPRM for 2012	CMS High Expediture Procedural Codes
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	0.90											X
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	1.16											X
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	1.25											X
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	0.80											X
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	1.18											X
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	1.20											X
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	1.46											X
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	1.19											X
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	1.43											X
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	1.80											X
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	2.00											X

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	High IWPUT	MPC List	CMS Request - PE Review	Harvard Valued - Utilization over 30,000	Harvard Valued - Utilization over 100,000	CMS Request - NPRM for 2012	CMS High Expediture Procedural Codes
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	New PE Inputs						X			X		X
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	41.32											X
33430	Replacement, mitral valve, with cardiopulmonary bypass	50.93					X						X
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	34.98											X
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	6.60	X										X
35476	Transluminal balloon angioplasty, percutaneous; venous	5.10	X										X
50590	Lithotripsy, extracorporeal shock wave	9.77											X
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	10.08											X
76830	Ultrasound, transvaginal	0.69											X
76872	Ultrasound, transrectal;	0.69											X
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	7.99	X						X				X
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated thresho	0.50						X					X

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	High IWPUT	MPC List	CMS Request - PE Review	Harvard Valued - Utilization over 30,000	Harvard Valued - Utilization over 100,000	CMS Request - NPRM for 2012	CMS High Expediture Procedural Codes
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report	0.75				X							
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report	0.45				X							
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	0.30				X							
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	New PE Inputs											X
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	New PE Inputs											X
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	New PE Inputs	X	X		X						X	
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	New PE Inputs	X			X						X	

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	High IWPUT	MPC List	CMS Request - PE Review	Harvard Valued - Utilization over 30,000	Harvard Valued - Utilization over 100,000	CMS Request - NPRM for 2012	CMS High Expediture Procedural Codes
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	New PE Inputs				X						X	
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	New PE Inputs				X						X	
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	New PE Inputs				X						X	
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	New PE Inputs				X						X	
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	New PE Inputs				X							
95939	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	New PE Inputs				X							

CPT 2013 RUC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0300XT	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG6	Apr12	12	ACC, STS	40.00	40.00		☑		☑
15740	090	R	Feb12	07	Island Pedicle Flap		Editorial						☑		☐
20665	010	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
22522	ZZZ	R	Oct11	EC-N	Percutaneous Vertebroplasty		Editorial						☑		☐
22586	090	N	Feb12	80	Presacral Lumbar Interbody Fusion	Z1	Apr12	06					☑	No Recommendation	☐
23331	090	F	Oct11	08	Shoulder Arthroplasty	E1	Apr12	04	ASSH, AAOS				☑	Referral to CPT Editorial Panel	☐
23332	090	F	Oct11	08	Shoulder Arthroplasty	E2	Apr12	04	ASSH, AAOS				☑	Referral to CPT Editorial Panel	☐
23472	090	F	Oct11	08	Shoulder Arthroplasty	E3	Apr12	04	ASSH, AAOS	22.13	22.13		☑		☐
23473	090	N	Oct11	08	Shoulder Arthroplasty	E4	Apr12	04	ASSH, AAOS	25.00	25.00		☑		☐
23474	090	N	Oct11	08	Shoulder Arthroplasty	E5	Apr12	04	ASSH, AAOS	27.21	27.21		☑		☐
24160	090	R	Oct11	09	Elbow Arthroplasty and Implant Removal	F1	Apr12	05	ASSH, AAOS				☑	Referral to CPT Editorial Panel	☐
24363	090	R	Oct11	09	Elbow Arthroplasty and Implant Removal	F2	Apr12	05	ASSH, AAOS	22.00	22.00		☑		☐
24370	090	N	Oct11	09	Elbow Arthroplasty and Implant Removal	F3	Apr12	05	ASSH, AAOS	23.55	23.55		☑		☐
24371	090	N	Oct11	09	Elbow Arthroplasty and Implant Removal	F4	Apr12	05	ASSH, AAOS	27.50	27.50		☑		☐
28890	090	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
29590	000	R	Feb12	08	Denis-Browne Splint Revision	FF1	Apr12	07	AAOS				☑		☐
31647	000	N	Oct11	43	Bronchial Valve Procedures	G1	Jan12	06	ACCP, ATS	4.40	4.40		☑		☑

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31648	000	N	Oct11	43	Bronchial Valve Procedures	G2	Jan12	06	ACCP, ATS	4.20	4.20		☑		☑
31649	ZZZ	N	Oct11	43	Bronchial Valve Procedures	G3	Jan12	06	ACCP, ATS	2.00	2.00		☑		☑
31651	ZZZ	N	Feb12	EC-H	Bronchial Valve Procedures	G4	Apr12	09	ACCP, ATS	1.58	1.58		☑		☑
31656	000	D	Feb12	22	Bronchography		Deleted						☑		☐
31660	000	N	Feb12	85	Bronchial Thermoplasty	AA1	Apr12	08	ACCP, ATS	4.50	4.50		☑		☐
31661	000	N	Feb12	85	Bronchial Thermoplasty	AA2	Apr12	08	ACCP, ATS	5.00	5.00		☑		☐
31715	000	D	Feb12	22	Bronchography		Deleted						☑		☐
32420	000	D	Feb12	10	Chest Tube Interventions		Apr12	11	ACCP, ATS, ACR				☑		☐
32421	000	D	Feb12	10	Chest Tube Interventions		Apr12	11	ACCP, ATS, ACR				☑		☐
32422	000	D	Feb12	10	Chest Tube Interventions		Apr12	11	ACCP, ATS, ACR				☑		☐
32551	000	R	Feb12	09	Chest Tube Thoracostomy	CC1	Apr12	10	ACCP, ATS, ACS, STS, SCCM	3.50	3.50		☑		☐
32554	000	N	Feb12	10	Chest Tube Interventions	DD1	Apr12	11	ACCP, ATS, ACR	1.83	1.54		☑	RUC Review October 2012	☐
32555	000	N	Feb12	10	Chest Tube Interventions	DD2	Apr12	11	ACCP, ATS, ACR	2.40	2.21		☑	RUC Review October 2012	☐
32556	000	N	Feb12	10	Chest Tube Interventions	DD3	Apr12	11	ACCP, ATS, ACR	2.50	2.19		☑	RUC Review October 2012	☐
32557	000	N	Feb12	10	Chest Tube Interventions	DD4	Apr12	11	ACCP, ATS, ACR	3.37	3.35		☑	RUC Review October 2012	☐
32701	000	N	Oct11	10	Stereotactic Body Radiation	H1	Jan12	07	STS	5.83	4.18		☑		☐
33225	ZZZ	R	Feb12	EC-H	Pacemaker or Pacing Cardioverter Defibrillator		Editorial						☑		☐
33361	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG1	Apr12	12	ACC, STS	29.50	29.50		☑		☑
33362	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG2	Apr12	12	ACC, STS	32.00	32.00		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
33363	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG3	Apr12	12	ACC, STS	33.00	33.00		☑		☑
33364	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG4	Apr12	12	ACC, STS	34.87	34.87		☑		☑
33365	000	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG5	Apr12	12	ACC, STS	37.50	37.50		☑		☑
33367	ZZZ	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG7	Apr12	12	ACC, STS	11.88	11.88		☑		☑
33368	ZZZ	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG8	Apr12	12	ACC, STS	14.39	14.39		☑		☑
33369	ZZZ	N	Feb12	82	Transcatheter Aortic Valve Replacement	GG9	Apr12	12	ACC, STS	19.00	19.00		☑		☑
33990	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH1	Apr12	13	ACC	12.00	8.15		☑		☐
33991	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH2	Apr12	13	ACC	16.63	11.88		☑		☐
33992	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH3	Apr12	13	ACC	6.44	4.00		☑		☐
33993	XXX	N	Feb12	84	Insertion of Percutaneous Ventricular Assist Device	HH4	Apr12	13	ACC	6.00	4.17		☑		☐
36010	XXX	R	Oct11	EC-P	Vascular Injection Procedures		Appendix G						☑		☐
36140	XXX	R	Oct11	EC-P	Vascular Injection Procedures		Appendix G						☑		☐
36221	000	N	Feb12	12	Cervicocerebal Angiography	S1	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	4.51	4.51		☑		☐
36222	000	N	Feb12	12	Cervicocerebal Angiography	S2	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	6.00	6.00		☑		☐

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36223	000	N	Feb12	12	Cervicocerebal Angiography	S3	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	6.50	6.50		☑		☐
36224	000	N	Feb12	12	Cervicocerebal Angiography	S4	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	7.55	7.55		☑		☐
36225	000	N	Feb12	12	Cervicocerebal Angiography	S5	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	6.50	6.50		☑		☐
36226	000	N	Feb12	12	Cervicocerebal Angiography	S6	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	7.55	7.55		☑		☐
36227	ZZZ	N	Feb12	12	Cervicocerebal Angiography	S7	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	2.32	2.32		☑		☐
36228	ZZZ	N	Feb12	12	Cervicocerebal Angiography	S8	Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS	4.25	4.25		☑		☐
37197	000	N	Jun11	06	Transcath Retrieval Intravascular Foreign Body	A1	Sep11	07	SVS, SIR, ACR	8.00	6.72		☑		☑
37201	000	D	Oct11	18	Bundle Thrombolysis		Jan12	08	ACR, SIR, SVS				☑		☐
37203	000	D	Jun11	06	Transcath Retrival Intervascualar Foreign Body		Sep11	07	SVS, SIR, ACR				☑		☐
37209	000	D	Oct11	18	Bundle Thrombolysis		Jan12	08	ACR, SIR, SVS				☑		☐
37211	000	N	Oct11	18	Bundle Thrombolysis	I1	Jan12	08	ACR, SIR, SVS	8.00	8.00		☑		☐
37212	000	N	Oct11	18	Bundle Thrombolysis	I2	Jan12	08	ACR, SIR, SVS	7.06	7.06		☑		☐
37213	000	N	Oct11	18	Bundle Thrombolysis	I3	Jan12	08	ACR, SIR, SVS	5.00	5.00		☑		☐
37214	000	N	Oct11	18	Bundle Thrombolysis	I4	Jan12	08	ACR, SIR, SVS	3.04	3.04		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
38240	XXX	R	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J1	Apr12	16	ASBMT	4.00	4.00		☑		☐
38241	XXX	R	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J2	Apr12	16	ASBMT	3.00	3.00		☑		☐
38242	XXX	R	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J4	Apr12	16	ASBMT	2.11	2.11		☑		☐
38243	XXX	N	Oct11	14	Bone Marrow Stem Cell Transplant Codes	J3	Apr12	16	ASBMT	2.13	2.13		☑		☐
43206	000	N	Feb12	23	Optical Endomicroscopy	NN2	Apr12	17	AGA, ASGE, CAP				☑	RUC Recommends Carrier Price	☐
43234	000	D	Feb12	11	Upper Gastrointestinal Endoscopy		Deleted						☑		☐
43252	000	N	Feb12	23	Optical Endomicroscopy	NN18	Apr12	17	AGA, ASGE, CAP				☑	RUC Recommends Carrier Price	☐
44705	XXX	N	Feb12	24	Fecal Bacteriotherapy	X1	Apr12	18	IDSA, AGA, ASGE	1.42	1.42		☑		☑
52287	000	N	Feb12	26	Bladder Chemodenervation	JJ1	Apr12	19	AUA	3.74	3.02		☑	RUC Review October 2012	☐
59300	000	R	Feb12	03	Other Qualified Healthcare Provider		Editorial						☑		☐
64561	010	R	Oct11	EC-M	Neurostimulator Code Revisions		Editorial						☑		☐
64612	010	R	Feb12	06	Chemodenervation for Chronic Migraine	DD1	Apr12	20	AAPMR, AAO-HNS, AAN, AAO	1.41	1.41		☑		☐
64613	010	F	Feb12	06	Chemodenervation for Chronic Migraine	DD2	Apr12	20	AAPMR, AAO-HNS, AAN, AAO				☑	Referral to CPT Editorial Panel	☐
64614	010	R	Feb12	06	Chemodenervation for Chronic Migraine	DD3	Apr12	20	AAPMR, AAO-HNS, AAN, AAO				☑	RUC Review October 2012	☐
64615	010	N	Feb12	06	Chemodenervation for Chronic Migraine	DD4	Apr12	20	AAPMR, AAO-HNS, AAN, AAO	1.85	1.85		☑		☐

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65800	000	R	Oct11	19	Paracentesis of the Eye	K1	Apr12	21	AAO	1.53	1.53		☑		☐
65805	000	D	Feb12	19	Paracentesis of the Eye		Apr12	21	AAO				☑		☐
67810	000	R	Jun11	08	Biopsy of Eyelid	B1	Sep11	08	AAO, AAD	1.18	1.18		☑		☐
71040	XXX	D	Feb12	22	Bronchography		Deleted						☑		☐
71060	XXX	D	Feb12	22	Bronchography		Deleted						☑		☐
72040	XXX	R	Oct11	17	X-Ray of Cervical Spine	L1	Jan12	09	ACR, ASNR	0.22	0.22	Yes	☑		☐
72050	XXX	R	Oct11	17	X-Ray of Cervical Spine	L2	Jan12	09	ACR, ASNR	0.31	0.31	Yes	☑		☐
72052	XXX	R	Oct11	17	X-Ray of Cervical Spine	L3	Jan12	09	ACR, ASNR	0.36	0.36	Yes	☑		☐
75650	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75660	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75662	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75665	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75671	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75676	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75680	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
75685	XXX	D	Feb12	12	Cervicocerebal Angiography		Apr12	14	ASNR, ACR, ACC, SIR, AAN, AANS, SVS				☑		☐
75896	XXX	R	Oct11	18	Bundle Thrombolysis	I5	Jan12	08	ACR, SIR, SVS				☑	RUC Review October 2012, RUC recommends Carrier Price	☐
75898	XXX	R	Oct11	18	Bundle Thrombolysis	I6	Jan12	08	ACR, SIR, SVS				☑	RUC Review October 2012, RUC recommends Carrier Price	☐
75900	XXX	D	Oct11	18	Bundle Thrombolysis		Jan12	08	ACR, SIR, SVS				☑		☐
75961	XXX	D	Jun11	06	Bundle Thrombolysis		Apr12	15	SIR, SVS				☑		☐
76000	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
76001	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
76376	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
76885	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
76886	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
77071	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
78000	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐
78001	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐
78003	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐
78006	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
78007	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐
78010	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐
78011	XXX	D	Feb12	13	Thyroid Uptake/Imaging		Apr12	22	SNM, ACNM, ACR				☑		☐
78012	XXX	N	Feb12	13	Thyroid Uptake/Imaging	T1	Apr12	22	SNM, ACNM, ACR	0.19	0.19		☑		☐
78013	XXX	N	Feb12	13	Thyroid Uptake/Imaging	T2	Apr12	22	SNM, ACNM, ACR	0.37	0.37		☑		☐
78014	XXX	N	Feb12	13	Thyroid Uptake/Imaging	T3	Apr12	22	SNM, ACNM, ACR	0.50	0.50		☑		☐
78070	XXX	R	Feb12	14	Parathyroid Imaging	U1	Apr12	23	SNM, ACNM, ACR	0.80	0.80		☑		☐
78071	XXX	N	Feb12	14	Parathyroid Imaging	U2	Apr12	23	SNM, ACNM, ACR	1.20	1.20		☑		☐
78072	XXX	N	Feb12	14	Parathyroid Imaging	U3	Apr12	23	SNM, ACNM, ACR	1.60	1.60		☑		☑
81201	XXX	N	Feb12	29	Molecular Pathology-Adenomatous Polyposis Coli	V1	Apr12	24	CAP	1.40	1.40		☑		☑
81202	XXX	N	Feb12	29	Molecular Pathology-Adenomatous Polyposis Coli	V2	Apr12	24	CAP	0.52	0.52		☑		☑
81203	XXX	N	Feb12	29	Molecular Pathology-Adenomatous Polyposis Coli	V3	Apr12	24	CAP	0.80	0.80		☑		☑
81235	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C1	Sep11	09	CAP	0.51	0.51		☑		☑
81252	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C2	Sep11	09	CAP	0.65	0.65		☑		☑
81253	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C3	Sep11	09	CAP	0.52	0.52		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
81254	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C4	Sep11	09	CAP	0.40	0.40		☑		☑
81321	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C5	Sep11	09	CAP	0.80	0.80		☑		☑
81322	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C6	Sep11	09	CAP	0.52	0.52		☑		☑
81323	XXX	N	Jun11	12	Molecular Pathology – Tier 1	C7	Sep11	09	CAP	0.65	0.65		☑		☑
81400	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81401	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81402	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81403	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81404	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81405	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81406	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81407	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81408	XXX	R	Feb12	28	Molecular Pathology-Tier 2A		Editorial						☑		☑
81500	XXX	N	Feb12	34	Ovarian Malignancy		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
81503	XXX	N	Feb12	35	OVA1 Biomarkers Gynecological Malignancy		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
81506	XXX	N	Feb12	36	Diabetes Pre-diagnostic Risk Screen		CLFS						☐	Not Typically Performed by Physicians at this Time	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
81509	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
81510	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
81511	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
81512	XXX	N	Feb12	37	Maternal Serum Penta Screen		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
81599	XXX	N	Feb12	33	Molecular Pathology-Multianalyte Assays		CLFS						☐	RUC Recommending Carrier Price	☐
82009	XXX	R	Jun11	11	Beta-Hydroxybutyrate Assay, Quantitative Blood		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
82010	XXX	R	Jun11	11	Beta-Hydroxybutyrate Assay, Quantitative Blood		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
82777	XXX	N	Oct11	26	Galectin-3 Assay		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
83890	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83891	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83892	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83893	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
83894	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83896	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83897	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83898	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83900	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83901	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83902	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83903	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83904	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83905	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83906	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83907	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83908	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83909	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
83912	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83913	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
83914	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
86148	XXX	R	Feb12	82	Cell Enumeration Circulating Tumor Cells		Apr12	Editorial	CAP				☑		☐
86152	XXX	N	Feb12	82	Cell Enumeration Circulating Tumor Cells		CLFS	25	CAP				☐	Not Typically Performed by Physicians at this Time	☑
86153	XXX	N	Feb12	82	Cell Enumeration Circulating Tumor Cells	W1	Apr12	25	CAP	0.69	0.69		☑		☑
86711	XXX	N	Feb12	41	Antibody Detection		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86828	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86829	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86830	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86831	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86832	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
86833	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86834	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
86835	XXX	N	Feb12	42	Solid Phase Antibody Testing		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87498	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87521	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87522	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87535	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87536	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87538	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87539	XXX	R	Feb12	43	Enterovirus Reverse Transcription		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87631	XXX	N	Oct11	28	Respiratory Virus Multiplex Nucleic Acid Assays		CLFS						☐	Not Typically Performed by Physicians at this Time	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
87632	XXX	N	Oct11	28	Respiratory Virus Multiplex Nucleic Acid Assays		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87633	XXX	N	Oct11	28	Respiratory Virus Multiplex Nucleic Acid Assays		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87901	XXX	R	Feb12	44	Viral Drug Resistance Genotyping		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87910	XXX	N	Feb12	44	Viral Drug Resistance Genotyping		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
87912	XXX	N	Feb12	44	Viral Drug Resistance Genotyping		CLFS						☐	Not Typically Performed by Physicians at this Time	☐
88375	XXX	N	Feb12	23	Optical Endomicroscopy	NN39	Apr12	17	CAP				☑	RUC Recommends Carrier Price	☐
88384	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
88385	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
88386	XXX	D	Feb12	31	Molecular Pathology-Deletion of Stacking Code		Deleted						☐		☐
90460	XXX	R	Jun11	14	Immunization Administration		Vaccine						☑		☐
90461	ZZZ	R	Jun11	14	Immunization Administration		Vaccine						☑		☐
90653	XXX	N	Feb12	63	Adjuvanted Influenza Vaccine		Vaccine						☐		☐
90655	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						☐		☐
90656	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
90657	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						☐		☐
90658	XXX	R	Feb12	61	Trivalent Influenza Vaccines		Vaccine						☐		☐
90660	XXX	R	Feb12	62	Intranasal Influenza Virus		Vaccine						☑		☐
90665	XXX	D	Oct11	30	Lyme Disease Vaccine		Vaccine						☑		☐
90672	XXX	N	Feb12	62	Intranasal Influenza Virus		Vaccine						☑		☐
90701	XXX	D	Jun11	15	Whole Cell DTP Vaccine		Vaccine						☑		☐
90718	XXX	D	Jun11	15	Tetanus and Diphtheria Toxoid		Vaccine						☑		☐
90739	XXX	N	Feb12	65	Hepatitis B		Vaccine						☑		☐
90746	XXX	R	Feb12	65	Hepatitis B		Vaccine						☑		☐
90785	ZZZ	N	Feb12	93	Psychotherapy	LL1	Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑	RUC Recommends Carrier Price	☐
90791	XXX	N	Feb12	93	Psychotherapy	LL2	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	3.00	3.00		☑		☐
90792	XXX	N	Feb12	93	Psychotherapy	LL3	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	3.25	3.25		☑		☐
90801	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90802	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
90804	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90805	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90806	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90807	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90808	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90809	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90810	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90811	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90812	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
90813	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90814	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90815	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90816	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90817	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90818	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90819	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90821	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90822	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
90823	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90824	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90826	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90827	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90828	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90829	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90832	XXX	N	Feb12	93	Psychotherapy	LL4	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	1.50	1.50		☑		☐
90833	ZZZ	N	Feb12	93	Psychotherapy	LL5	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	1.50	1.50		☑		☐
90834	XXX	N	Feb12	93	Psychotherapy	LL6	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	2.00	2.00		☑		☐

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90836	ZZZ	N	Feb12	93	Psychotherapy	LL7	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	1.90	1.90		☑		☐
90837	XXX	N	Feb12	93	Psychotherapy	LL8	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	2.25	3.00		☑		☐
90838	ZZZ	N	Feb12	93	Psychotherapy	LL9	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	2.10	2.50		☑		☐
90839	XXX	N	Feb12	93	Psychotherapy	LL10	Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑	RUC Recommends Carrier Price	☐
90840	ZZZ	N	Feb12	93	Psychotherapy	LL11	Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑	RUC Recommends Carrier Price	☐
90845	XXX	F	Feb12	93	Psychotherapy	LL12	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	0.00	2.10		☑	Reaffirm RUC recommendation from September 2011	☐
90846	XXX	F	Feb12	93	Psychotherapy	LL13	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	2.40	2.40		☑		☐
90847	XXX	F	Feb12	93	Psychotherapy	LL14	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	2.50	2.50		☑		☐
90849	XXX	F	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐

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90853	XXX	R	Feb12	93	Psychotherapy	LL15	Apr12	26	APA, NASW, AACAP, APA (HCPAC)	0.59	0.59	Yes	☑		☐
90857	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90862	XXX	D	Feb12	93	Psychotherapy		Apr12	26	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90875	XXX	R	Feb12	93	Psychotherapy		Apr12	Editorial	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90876	XXX	R	Feb12	93	Psychotherapy		Apr12	Editorial	APA, NASW, AACAP, APA (HCPAC)				☑		☐
90889	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
91110	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
91111	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
91112	XXX	N	Feb12	67	Wireless Motility Capsule	Y1	Apr12	27	AGA, ASGE	2.10	2.10		☑		☑
92286	XXX	R	Oct11	20	Anterior Segment Imaging	M1	Apr12	28	AAO, AOA	0.40	0.40		☑		☐
92287	XXX	R	Oct11	20	Anterior Segment Imaging	M2	Apr12	28	AAO, AOA				☑	Referral to CPT Assistant	☐
92920	000	N	Oct11	21	Percutaneous Coronary Intervention	N1	Jan12	10	ACC	9.25	9.00		☑		☐
92921	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N2	Jan12	10	ACC	4.00	4.00		☑		☐

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92924	000	N	Oct11	21	Percutaneous Coronary Intervention	N3	Jan12	10	ACC	12.00	11.00		☑		☐
92925	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N4	Jan12	10	ACC	5.00	5.00		☑		☐
92928	000	N	Oct11	21	Percutaneous Coronary Intervention	N5	Jan12	10	ACC	10.49	10.49		☑		☐
92929	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N6	Jan12	10	ACC	5.00	4.44		☑		☐
92933	000	N	Oct11	21	Percutaneous Coronary Intervention	N7	Jan12	10	ACC	14.00	12.32		☑		☐
92934	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N8	Jan12	10	ACC	5.50	5.50		☑		☐
92937	000	N	Oct11	21	Percutaneous Coronary Intervention	N9	Jan12	10	ACC	11.00	10.49		☑		☐
92938	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N10	Jan12	10	ACC	5.00	6.00		☑		☐
92941	000	N	Oct11	21	Percutaneous Coronary Intervention	N11	Jan12	10	ACC	12.32	12.32		☑		☐
92943	000	N	Oct11	21	Percutaneous Coronary Intervention	N12	Jan12	10	ACC	12.32	12.32		☑		☐
92944	ZZZ	N	Oct11	21	Percutaneous Coronary Intervention	N13	Jan12	10	ACC	6.00	6.00		☑		☐
92973	ZZZ	R	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐
92980	000	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐
92981	ZZZ	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
92982	000	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐
92984	ZZZ	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐
92995	000	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐
92996	ZZZ	D	Oct11	21	Percutaneous Coronary Intervention		Jan12	10	ACC				☑		☐
93015	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial			0.75	0.75	Yes	☑		☐
93016	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial		ACC	0.45	0.45	Yes	☑		☐
93224	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial		ACC				☑		☐
93227	XXX	R	Feb12	03	Qualified Helathcare Professional		Editorial						☑		☐
93228	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93229	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93268	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93272	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93279	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93286	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93288	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93293	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93294	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93295	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93297	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93298	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☑
93351	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93651	000	D	Oct11	22	Bundling EPS and Transcatheter Ablation		Jan12	11	ACC, HRS				☑		☐
93652	000	D	Oct11	22	Bundling EPS and Transcatheter Ablation		Jan12	11	ACC, HRS				☑		☐
93653	000	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q1	Jan12	11	ACC, HRS	18.00	15.00		☑		☐
93654	000	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q2	Jan12	11	ACC, HRS	25.00	20.00		☑		☐
93655	ZZZ	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q3	Jan12	11	ACC, HRS	9.00	9.00		☑		☐
93656	000	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q4	Jan12	11	ACC, HRS	23.40	20.02		☑		☐
93657	ZZZ	N	Oct11	22	Bundling EPS and Transcatheter Ablation	Q5	Jan12	11	ACC, HRS	10.00	10.00		☑		☐
93745	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93750	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93790	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
93797	000	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
94014	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
94016	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
94452	XXX	R	Feb12	03	Qualified Healhtcare Professional		Editorial						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
94610	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
94774	YYY	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
94777	YYY	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95004	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95010	XXX	R	Feb12	15	Percutaneous Allergy Testing		Apr12	29	JCAAI				☑		☐
95015	XXX	R	Feb12	15	Percutaneous Allergy Testing		Apr12	29	JCAAI				☑		☐
95017	XXX	N	Feb12	15	Percutaneous Allergy Testing	EE1	Apr12	29	JCAAI				☑		☐
95024	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95027	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95075	ZZZ	D	Feb12	71	Allergen Ingestion Challenge Test		Apr12	30	JCAAI				☑		☐
95076	XXX	N	Feb12	71	Allergen Ingestion Challenge Test	MM1	Apr12	30	JCAAI	1.50	1.50		☑		☐
95079	XXX	N	Feb12	71	Allergen Ingestion Challenge Test	MM2	Apr12	30	JCAAI	1.38	1.38		☑		☐
95018	XXX	N	Feb12	15	Percutaneous Allergy Testing	EE2	Apr12	29	JCAAI				☑		☐
95120	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95782	XXX	N	Feb12	73	Pediatric Polysomnography	KK1	Apr12	31	AASM, AAP, ACCP, ATS, AAN	3.00	3.00		☑		☐
95783	XXX	N	Feb12	73	Pediatric Polysomnography	KK2	Apr12	31	AASM, AAP, ACCP, ATS, AAN	3.20	3.20		☑		☐
95808	XXX	R	Feb12	73	Pediatric Polysomnography		Editorial	31	AASM, AAP, ACCP, ATS, AAN				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
95810	XXX	R	Feb12	73	Pediatric Polysomnography		Editorial	31	AASM, AAP, ACCP, ATS, AAN				☑		☐
95811	XXX	R	Feb12	73	Pediatric Polysomnography		Editorial	31	AASM, AAP, ACCP, ATS, AAN				☑		☐
95830	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95860	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R1	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.96	0.96	Yes	☑		☐
95861	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R2	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.54	1.54	Yes	☑		☐
95863	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R3	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.87	1.87	Yes	☑		☐
95864	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R4	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.99	1.99	Yes	☑		☐
95865	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R5	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.57	1.57	Yes	☑		☐
95866	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R6	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.25	1.25	Yes	☑		☐
95867	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R7	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.79	0.79	Yes	☑		☐
95868	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R8	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.18	1.18	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
95869	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R9	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.37	0.37	Yes	☑		☐
95870	XXX	F	Feb12	16	EMG in conjunction with nerve testing	R10	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.37	0.37	Yes	☑		☐
95885	ZZZ	F	Feb12	16	EMG in Conjunction with Nerve Testing	R11	Apr12	32	AAN, AAPMR, AANEM, APTA				☑	Reaffirm RUC recommendation from April 2011 RUC Meeting	☐
95886	ZZZ	F	Feb12	16	EMG in Conjunction with Nerve Testing	R12	Apr12	32	AAN, AAPMR, AANEM, APTA				☑	Reaffirm RUC recommendation from April 2011 RUC Meeting	☐
95887	ZZZ	F	Feb12	16	EMG in Conjunction with Nerve Testing	R13	Apr12	32	AAN, AAPMR, AANEM, APTA				☑	Reaffirm RUC recommendation from April 2011 RUC Meeting	☐
95900	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				☑		☐
95903	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				☑		☐
95904	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				☑		☐
95905	XXX	F	Feb12	16	EMG in Conjunction with Nerve Testing	R21	Apr12	32	AAN, AAPMR, AANEM, APTA				☑	Reaffirm RUC recommendation from October 2009 RUC Meeting	☑
95907	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R14	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.00	1.00		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
95908	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R15	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	1.68	1.37		☑		☐
95909	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R16	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	2.28	1.77		☑		☐
95910	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R17	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	2.90	2.80		☑		☐
95911	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R18	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	3.44	3.34		☑		☐
95912	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R19	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	4.10	4.00		☑		☐
95913	XXX	N	Feb12	16	EMG in conjunction with nerve testing	R20	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	4.30	4.20		☑		☐
95920	ZZZ	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				☑		☐
95921	XXX	F	Feb12	17	Autonomic Funtion Testing	BB1	Apr12	33	AANEM, AAN	0.90	0.90	Yes	☑		☐
95922	XXX	F	Feb12	17	Autonomic Funtion Testing	BB2	Apr12	33	AANEM, AAN	1.10	0.96	Yes	☑		☐
95923	XXX	F	Feb12	17	Autonomic Funtion Testing	BB4	Apr12	33	AANEM, AAN	0.90	0.90	Yes	☑		☐
95924	XXX	N	Feb12	17	Autonomic Funtion Testing		Apr12	33	AANEM, ACP, AAN	1.89	1.86		☑	RUC Review October 2012, RUC Recommends Interim Value	☐
95930	XXX	R	Feb12	77	Vision Screening		Editorial						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
95934	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				☑		☐
95936	XXX	D	Feb12	16	EMG in conjunction with nerve testing		Apr12	32	AANEM, AAPMR, AAN, APTA, AAN				☑		☐
95940	ZZZ	N	Oct11	EC-C	Intraoperative Neurophysiology Monitoring	P1	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	0.60	0.60		☑		☑
95941	ZZZ	N	Oct11	EC-C	Intraoperative Neurophysiology Monitoring	P2	Apr12	32	AANEM, AAPMR, AAN, APTA, AAN	2.00	2.00		☑		☑
95943	XXX	N	Feb12	17	Autonomic Funtion Testing	BB5	Apr12	33	AANEM, AAN				☑	RUC Review October 2012	☐
95954	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95961	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95962	ZZZ	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
95991	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
96004	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
97530	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
97532	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
97533	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
97535	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
97537	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
97755	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
98969	XXX	R	Oct11	36	Online Medical Evaluation		Editorial						☑		☐
99000	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99001	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99002	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99070	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99071	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99078	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99091	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99143	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99148	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99174	XXX	R	Feb12	77	Vision Screening		Editorial						☑		☐
99183	XXX	R	Feb12	03	Qualified Healthcare Professional		Editorial						☑		☐
99234	XXX	R	Feb12	18	Observation or Inpatient Care		Editorial						☑		☐
99235	XXX	R	Feb12	18	Observation or Inpatient Care		Editorial						☑		☐
99236	XXX	R	Feb12	18	Observation or Inpatient Care		Editorial						☑		☐
99444	XXX	R	Oct11	36	Online Medical Evaluation		Editorial						☑		☐
99486	XXX	N	Oct11	03	Neonatal Pediatric Transport	Q1	Jan12	13	AAP, SCCM	1.30	1.30		☑		☐
99487	ZZZ	N	Oct11	03	Neonatal Pediatric Transport	Q2	Jan12	13	AAP, SCCM				☑		☐

CPT 2013 HCPAC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	HCPAC Date	HCPAC Tab	S.S.	Specialty Rec	HCPAC Rec	Same RVU as last year?	MFS?	Comments
90863	ZZZ	N	Feb12	93	Psychotherapy	LL16	HCPAC	55	APA, NASW, AACAP, APA (HCPAC)				☑	HCPAC, RUC Recommends Carrier Price

Status Report: CMS Requests and Relativity Assessment Issues

01930 **Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified**

Global: XXX **Issue:** Anesthesia for Interventional Radiology **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 17,975

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0 **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: 0 **2012 Fac PE RVU:** 0.00

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

10022 **Fine needle aspiration; with imaging guidance**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, SIR, CAP, ACR, ASC **First Identified:** October 2008 **2010 Medicare Utilization Data:** 156,225

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 2.41 **2012 NF PE RVU:** 2.61
2007 Fac PE RVU: 0.4 **2012 Fac PE RVU:** 0.49

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

10060 **Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single**

Global: 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 526,284

2007 Work RVU: 1.19 **2012 Work RVU:** 1.22
2007 NF PE RVU: 1.29 **2012 NF PE RVU:** 1.98
2007 Fac PE RVU: 0.97 **2012 Fac PE RVU:** 1.43

RUC Recommendation: 1.50 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10061 **Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple**

Global: 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 07 **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 185,693

2007 Work RVU: 2.42 **2012 Work RVU:** 2.45
2007 NF PE RVU: 1.89 **2012 NF PE RVU:** 3.06
2007 Fac PE RVU: 1.51 **2012 Fac PE RVU:** 2.34

RUC Recommendation: 2.45 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

10120 **Incision and removal of foreign body, subcutaneous tissues; simple**

Global: 010 **Issue:** **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 12 **Specialty Developing Recommendation:** APMA, AAFP **First Identified:** April 2011 **2010 Medicare Utilization Data:** 41,220

2007 Work RVU: 1.23 **2012 Work RVU:** 1.25
2007 NF PE RVU: 2.12 **2012 NF PE RVU:** 2.69
2007 Fac PE RVU: 0.97 **2012 Fac PE RVU:** 1.31

RUC Recommendation: 1.25 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

11040 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 775,290

2007 Work RVU: 0.50 **2012 Work RVU:**
2007 NF PE RVU: 0.56 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11041 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 700,327

2007 Work RVU: 0.60 **2012 Work RVU:**
2007 NF PE RVU: 0.68 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.3 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11042 **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,290,599

2007 Work RVU: 0.80 **2012 Work RVU:** 1.01
2007 NF PE RVU: 0.97 **2012 NF PE RVU:** 2.04
2007 Fac PE RVU: 0.39 **2012 Fac PE RVU:** 0.61

RUC Recommendation: 1.12 **CPT Action (if applicable):** October 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11043 **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 192,920

2007 Work RVU: 3.04 **2012 Work RVU:** 2.7
2007 NF PE RVU: 3.45 **2012 NF PE RVU:** 3.65
2007 Fac PE RVU: 2.62 **2012 Fac PE RVU:** 1.50

RUC Recommendation: 3.00 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11044 **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 53,754

2007 Work RVU: 4.11 **2012 Work RVU:** 4.1
2007 NF PE RVU: 4.58 **2012 NF PE RVU:** 4.59
2007 Fac PE RVU: 3.73 **2012 Fac PE RVU:** 2.13

RUC Recommendation: 4.56 **CPT Action (if applicable):** October 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11045 **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.5
2007 NF PE RVU: **2012 NF PE RVU:** 0.59
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.18

RUC Recommendation: 0.69 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11046 **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.03
2007 NF PE RVU: **2012 NF PE RVU:** 0.90
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.41

RUC Recommendation: 1.29 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11047 **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.8
2007 NF PE RVU: **2012 NF PE RVU:** 1.43
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.74

RUC Recommendation: 2.00 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11055 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion**

Global: 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2010 Medicare Utilization Data:** 827,969

2007 Work RVU: 0.43 **2012 Work RVU:** 0.43
2007 NF PE RVU: 0.63 **2012 NF PE RVU:** 1.00
2007 Fac PE RVU: 0.16 **2012 Fac PE RVU:** 0.13

RUC Recommendation: Maintain **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11056 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions**

Global: 000 **Issue:** Trim Skin Lesions **Screen:** MPC List / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 53 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,767,424

2007 Work RVU: 0.61 **2012 Work RVU:** 0.5
2007 NF PE RVU: 0.7 **2012 NF PE RVU:** 1.11
2007 Fac PE RVU: 0.22 **2012 Fac PE RVU:** 0.15

RUC Recommendation: 0.50 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11057 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions**

Global: 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2010 Medicare Utilization Data:** 362,420

2007 Work RVU: 0.79 **2012 Work RVU:** 0.79
2007 NF PE RVU: 0.81 **2012 NF PE RVU:** 1.21
2007 Fac PE RVU: 0.28 **2012 Fac PE RVU:** 0.23

RUC Recommendation: Maintain **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11100 **Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 2,702,008

2007 Work RVU: 0.81 **2012 Work RVU:** 0.81
2007 NF PE RVU: 1.41 **2012 NF PE RVU:** 2.13
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** 0.53

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11101 **Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** **Screen:** Low Value Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,173,566

2007 Work RVU: 0.41 **2012 Work RVU:** 0.41
2007 NF PE RVU: 0.35 **2012 NF PE RVU:** 0.50
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:** 0.27

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11300 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 88,442

2007 Work RVU: 0.51 **2012 Work RVU:** 0.51
2007 NF PE RVU: 1.04 **2012 NF PE RVU:** 1.47
2007 Fac PE RVU: 0.21 **2012 Fac PE RVU:** 0.30

RUC Recommendation: 0.60 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11301 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 176,259

2007 Work RVU: 0.85 **2012 Work RVU:** 0.85
2007 NF PE RVU: 1.21 **2012 NF PE RVU:** 1.78
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** 0.53

RUC Recommendation: 0.90 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11302 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm** **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 107,174

2007 Work RVU: 1.05 **2012 Work RVU:** 1.05
2007 NF PE RVU: 1.42 **2012 NF PE RVU:** 2.08
2007 Fac PE RVU: 0.47 **2012 Fac PE RVU:** 0.66

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11303 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm** **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 16,945

2007 Work RVU: 1.24 **2012 Work RVU:** 1.24
2007 NF PE RVU: 1.69 **2012 NF PE RVU:** 2.44
2007 Fac PE RVU: 0.53 **2012 Fac PE RVU:** 0.77

RUC Recommendation: 1.25 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11305 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less** **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 115,473

2007 Work RVU: 0.67 **2012 Work RVU:** 0.67
2007 NF PE RVU: 0.91 **2012 NF PE RVU:** 1.32
2007 Fac PE RVU: 0.26 **2012 Fac PE RVU:** 0.25

RUC Recommendation: 0.80 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11306 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm** **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 104,350

2007 Work RVU: 0.99 **2012 Work RVU:** 0.99
2007 NF PE RVU: 1.18 **2012 NF PE RVU:** 1.70
2007 Fac PE RVU: 0.41 **2012 Fac PE RVU:** 0.47

RUC Recommendation: 1.18 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11307 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 49,955

2007 Work RVU: 1.14 **2012 Work RVU:** 1.14
2007 NF PE RVU: 1.4 **2012 NF PE RVU:** 2.01
2007 Fac PE RVU: 0.49 **2012 Fac PE RVU:** 0.60

RUC Recommendation: 1.20 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11308 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 11,389

2007 Work RVU: 1.41 **2012 Work RVU:** 1.41
2007 NF PE RVU: 1.53 **2012 NF PE RVU:** 2.09
2007 Fac PE RVU: 0.58 **2012 Fac PE RVU:** 0.61

RUC Recommendation: 1.46 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11310 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 85,938

2007 Work RVU: 0.73 **2012 Work RVU:** 0.73
2007 NF PE RVU: 1.18 **2012 NF PE RVU:** 1.68
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.44

RUC Recommendation: 1.19 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11311 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 119,760

2007 Work RVU: 1.05 **2012 Work RVU:** 1.05
2007 NF PE RVU: 1.34 **2012 NF PE RVU:** 1.95
2007 Fac PE RVU: 0.49 **2012 Fac PE RVU:** 0.67

RUC Recommendation: 1.43 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11312 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 52,616

2007 Work RVU: 1.20 **2012 Work RVU:** 1.2
2007 NF PE RVU: 1.55 **2012 NF PE RVU:** 2.26
2007 Fac PE RVU: 0.56 **2012 Fac PE RVU:** 0.77

RUC Recommendation: 1.80 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11313 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2010 Medicare Utilization Data:** 7,226

2007 Work RVU: 1.62 **2012 Work RVU:** 1.62
2007 NF PE RVU: 1.9 **2012 NF PE RVU:** 2.66
2007 Fac PE RVU: 0.73 **2012 Fac PE RVU:** 1.01

RUC Recommendation: 2.00 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11719 **Trimming of nondystrophic nails, any number**

Global: 000 **Issue:** Debridement of Nail **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 32 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,488,242

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.28 **2012 NF PE RVU:** 0.47
2007 Fac PE RVU: 0.07 **2012 Fac PE RVU:** 0.05

RUC Recommendation: 0.17 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11720 **Debridement of nail(s) by any method(s); 1 to 5**

Global: 000 **Issue:** Debridement of Nail **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 53 **Specialty Developing Recommendation:** APMA **First Identified:** **2010 Medicare Utilization Data:** 2,188,616

2007 Work RVU: 0.32 **2012 Work RVU:** 0.32
2007 NF PE RVU: 0.37 **2012 NF PE RVU:** 0.57
2007 Fac PE RVU: 0.11 **2012 Fac PE RVU:** 0.09

RUC Recommendation: 0.32 (Interim) **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11721 **Debridement of nail(s) by any method(s); 6 or more** **Global:** 000 **Issue:** Debridement of Nail **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 53 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2010 Medicare Utilization Data:** 7,631,434

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 0.47 **2012 NF PE RVU:** 0.70
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:** 0.16

RUC Recommendation: 0.54 (Interim) **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11900 **Injection, intralesional; up to and including 7 lesions** **Global:** 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 31 **Specialty Developing Recommendation:** AAD **First Identified:** October 2009 **2010 Medicare Utilization Data:** 156,008

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 0.72 **2012 NF PE RVU:** 1.05
2007 Fac PE RVU: 0.22 **2012 Fac PE RVU:** 0.34

RUC Recommendation: 0.52 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11901 **Injection, intralesional; more than 7 lesions** **Global:** 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 31 **Specialty Developing Recommendation:** AAD **First Identified:** February 2010 **2010 Medicare Utilization Data:** 52,713

2007 Work RVU: 0.80 **2012 Work RVU:** 0.8
2007 NF PE RVU: 0.75 **2012 NF PE RVU:** 1.15
2007 Fac PE RVU: 0.37 **2012 Fac PE RVU:** 0.53

RUC Recommendation: 0.80 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11981 **Insertion, non-biodegradable drug delivery implant** **Global:** XXX **Issue:** Drug Implant **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2010 Medicare Utilization Data:** 13,332

2007 Work RVU: 1.48 **2012 Work RVU:** 1.48
2007 NF PE RVU: 1.76 **2012 NF PE RVU:** 2.26
2007 Fac PE RVU: 0.66 **2012 Fac PE RVU:** 0.69

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11982 **Removal, non-biodegradable drug delivery implant** **Global:** XXX **Issue:** Drug Implant **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 3,385

2007 Work RVU: 1.78 **2012 Work RVU:** 1.78
2007 NF PE RVU: 1.97 **2012 NF PE RVU:** 2.45
2007 Fac PE RVU: 0.81 **2012 Fac PE RVU:** 0.85

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

11983 **Removal with reinsertion, non-biodegradable drug delivery implant** **Global:** XXX **Issue:** Drug Implant **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2010 Medicare Utilization Data:** 6,099

2007 Work RVU: 3.30 **2012 Work RVU:** 3.3
2007 NF PE RVU: 2.38 **2012 NF PE RVU:** 2.70
2007 Fac PE RVU: 1.44 **2012 Fac PE RVU:** 1.39

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

12001 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less** **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 179,272

2007 Work RVU: 1.72 **2012 Work RVU:** 0.84
2007 NF PE RVU: 1.92 **2012 NF PE RVU:** 1.77
2007 Fac PE RVU: 0.76 **2012 Fac PE RVU:** 0.48

RUC Recommendation: 0.84 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12002 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm** **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 139,131

2007 Work RVU: 1.88 **2012 Work RVU:** 1.14
2007 NF PE RVU: 1.98 **2012 NF PE RVU:** 1.95
2007 Fac PE RVU: 0.89 **2012 Fac PE RVU:** 0.57

RUC Recommendation: 1.14 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12004 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 21,241

2007 Work RVU: 2.26 **2012 Work RVU:** 1.44
2007 NF PE RVU: 2.26 **2012 NF PE RVU:** 2.19
2007 Fac PE RVU: 0.99 **2012 Fac PE RVU:** 0.66

RUC Recommendation: 1.44 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12005 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 5,450

2007 Work RVU: 2.88 **2012 Work RVU:** 1.97
2007 NF PE RVU: 2.75 **2012 NF PE RVU:** 2.70
2007 Fac PE RVU: 1.17 **2012 Fac PE RVU:** 0.82

RUC Recommendation: 1.97 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12006 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 1,032

2007 Work RVU: 3.68 **2012 Work RVU:** 2.39
2007 NF PE RVU: 3.3 **2012 NF PE RVU:** 3.23
2007 Fac PE RVU: 1.46 **2012 Fac PE RVU:** 1.01

RUC Recommendation: 2.39 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12007 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 355

2007 Work RVU: 4.13 **2012 Work RVU:** 2.9
2007 NF PE RVU: 3.71 **2012 NF PE RVU:** 3.60
2007 Fac PE RVU: 1.73 **2012 Fac PE RVU:** 1.25

RUC Recommendation: 2.90 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12011 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 88,270

2007 Work RVU: 1.78 **2012 Work RVU:** 1.07
2007 NF PE RVU: 2.07 **2012 NF PE RVU:** 2.04
2007 Fac PE RVU: 0.78 **2012 Fac PE RVU:** 0.53

RUC Recommendation: 1.07 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12013 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 50,284

2007 Work RVU: 2.01 **2012 Work RVU:** 1.22
2007 NF PE RVU: 2.22 **2012 NF PE RVU:** 2.19
2007 Fac PE RVU: 0.92 **2012 Fac PE RVU:** 0.59

RUC Recommendation: 1.22 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12014 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 6,496

2007 Work RVU: 2.48 **2012 Work RVU:** 1.57
2007 NF PE RVU: 2.5 **2012 NF PE RVU:** 2.41
2007 Fac PE RVU: 1.04 **2012 Fac PE RVU:** 0.69

RUC Recommendation: 1.57 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12015 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 3,183

2007 Work RVU: 3.21 **2012 Work RVU:** 1.98
2007 NF PE RVU: 3.04 **2012 NF PE RVU:** 2.91
2007 Fac PE RVU: 1.22 **2012 Fac PE RVU:** 0.80

RUC Recommendation: 1.98 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12016 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 465

2007 Work RVU: 3.94 **2012 Work RVU:** 2.68
2007 NF PE RVU: 3.45 **2012 NF PE RVU:** 3.33
2007 Fac PE RVU: 1.47 **2012 Fac PE RVU:** 1.04

RUC Recommendation: 2.68 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12017 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 80

2007 Work RVU: 4.72 **2012 Work RVU:** 3.18
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.79 **2012 Fac PE RVU:** 1.05

RUC Recommendation: 3.18 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12018 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** **2010 Medicare Utilization Data:** 32

2007 Work RVU: 5.54 **2012 Work RVU:** 3.61
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.19 **2012 Fac PE RVU:** 1.31

RUC Recommendation: 3.61 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12031 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 55,639

2007 Work RVU: 2.17 **2012 Work RVU:** 2
2007 NF PE RVU: 2.69 **2012 NF PE RVU:** 4.59
2007 Fac PE RVU: 1.17 **2012 Fac PE RVU:** 2.18

RUC Recommendation: 2.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

12032 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 192,852

2007 Work RVU: 2.49 **2012 Work RVU:** 2.52
2007 NF PE RVU: 4.19 **2012 NF PE RVU:** 6.05
2007 Fac PE RVU: 1.92 **2012 Fac PE RVU:** 2.87

RUC Recommendation: 2.52 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12034 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 20,265

2007 Work RVU: 2.94 **2012 Work RVU:** 2.97
2007 NF PE RVU: 3.54 **2012 NF PE RVU:** 5.61
2007 Fac PE RVU: 1.59 **2012 Fac PE RVU:** 2.59

RUC Recommendation: 2.97 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12035 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 4,867

2007 Work RVU: 3.44 **2012 Work RVU:** 3.5
2007 NF PE RVU: 5.21 **2012 NF PE RVU:** 6.96
2007 Fac PE RVU: 2.14 **2012 Fac PE RVU:** 2.90

RUC Recommendation: 3.60 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12036 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,030

2007 Work RVU: 4.06 **2012 Work RVU:** 4.23
2007 NF PE RVU: 5.51 **2012 NF PE RVU:** 7.30
2007 Fac PE RVU: 2.47 **2012 Fac PE RVU:** 3.22

RUC Recommendation: 4.50 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12037 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 599

2007 Work RVU: 4.68 **2012 Work RVU:** 5
2007 NF PE RVU: 6.05 **2012 NF PE RVU:** 7.89
2007 Fac PE RVU: 2.88 **2012 Fac PE RVU:** 3.68

RUC Recommendation: 5.25 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12041 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 18,713

2007 Work RVU: 2.39 **2012 Work RVU:** 2.1
2007 NF PE RVU: 2.87 **2012 NF PE RVU:** 4.63
2007 Fac PE RVU: 1.29 **2012 Fac PE RVU:** 2.19

RUC Recommendation: 2.10 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

12042 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 42,162

2007 Work RVU: 2.76 **2012 Work RVU:** 2.79
2007 NF PE RVU: 3.57 **2012 NF PE RVU:** 5.29
2007 Fac PE RVU: 1.63 **2012 Fac PE RVU:** 2.70

RUC Recommendation: 2.79 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12044 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,175

2007 Work RVU: 3.16 **2012 Work RVU:** 3.19
2007 NF PE RVU: 3.74 **2012 NF PE RVU:** 6.65
2007 Fac PE RVU: 1.69 **2012 Fac PE RVU:** 2.59

RUC Recommendation: 3.19 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12045 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 404

2007 Work RVU: 3.65 **2012 Work RVU:** 3.75
2007 NF PE RVU: 5.21 **2012 NF PE RVU:** 7.12
2007 Fac PE RVU: 2.23 **2012 Fac PE RVU:** 3.38

RUC Recommendation: 3.90 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12046 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 80

2007 Work RVU: 4.26 **2012 Work RVU:** 4.3
2007 NF PE RVU: 6.28 **2012 NF PE RVU:** 8.02
2007 Fac PE RVU: 2.64 **2012 Fac PE RVU:** 3.74

RUC Recommendation: 4.60 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12047 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 45

2007 Work RVU: 4.66 **2012 Work RVU:** 4.95
2007 NF PE RVU: 6.3 **2012 NF PE RVU:** 9.23
2007 Fac PE RVU: 2.95 **2012 Fac PE RVU:** 4.07

RUC Recommendation: 5.50 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12051 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 58,514

2007 Work RVU: 2.49 **2012 Work RVU:** 2.33
2007 NF PE RVU: 3.48 **2012 NF PE RVU:** 4.93
2007 Fac PE RVU: 1.57 **2012 Fac PE RVU:** 2.40

RUC Recommendation: 2.33 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

12052 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 75,927

2007 Work RVU: 2.81 **2012 Work RVU:** 2.87
2007 NF PE RVU: 3.64 **2012 NF PE RVU:** 5.43
2007 Fac PE RVU: 1.72 **2012 Fac PE RVU:** 2.81

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

12053 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 9,021

2007 Work RVU: 3.14 **2012 Work RVU:** 3.17
2007 NF PE RVU: 3.77 **2012 NF PE RVU:** 6.41
2007 Fac PE RVU: 1.68 **2012 Fac PE RVU:** 2.74

RUC Recommendation: 3.17 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12054 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 3,113

2007 Work RVU: 3.47 **2012 Work RVU:** 3.5
2007 NF PE RVU: 4.02 **2012 NF PE RVU:** 6.63
2007 Fac PE RVU: 1.74 **2012 Fac PE RVU:** 2.65

RUC Recommendation: 3.50 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12055 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 414

2007 Work RVU: 4.44 **2012 Work RVU:** 4.5
2007 NF PE RVU: 4.87 **2012 NF PE RVU:** 8.38
2007 Fac PE RVU: 2.13 **2012 Fac PE RVU:** 3.49

RUC Recommendation: 4.65 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12056 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 58

2007 Work RVU: 5.25 **2012 Work RVU:** 5.3
2007 NF PE RVU: 6.62 **2012 NF PE RVU:** 9.88
2007 Fac PE RVU: 2.89 **2012 Fac PE RVU:** 4.92

RUC Recommendation: 5.50 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12057 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 39

2007 Work RVU: 5.97 **2012 Work RVU:** 6
2007 NF PE RVU: 6.47 **2012 NF PE RVU:** 11.40
2007 Fac PE RVU: 3.53 **2012 Fac PE RVU:** 5.06

RUC Recommendation: 6.28 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

13100 **Repair, complex, trunk; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** **2010 Medicare Utilization Data:** 5,175

2007 Work RVU: 3.14 **2012 Work RVU:** 3.17
2007 NF PE RVU: 4.15 **2012 NF PE RVU:** 5.53
2007 Fac PE RVU: 2.35 **2012 Fac PE RVU:** 3.24

RUC Recommendation: 3.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13101 **Repair, complex, trunk; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** **2010 Medicare Utilization Data:** 59,565

2007 Work RVU: 3.93 **2012 Work RVU:** 3.96
2007 NF PE RVU: 4.99 **2012 NF PE RVU:** 7.10
2007 Fac PE RVU: 2.77 **2012 Fac PE RVU:** 3.82

RUC Recommendation: 3.50 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13102 **Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.24 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13120 **Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 7,851

2007 Work RVU: 3.32 **2012 Work RVU:** 3.35
2007 NF PE RVU: 4.26 **2012 NF PE RVU:** 5.69
2007 Fac PE RVU: 2.41 **2012 Fac PE RVU:** 3.37

RUC Recommendation: 3.23 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

13121 **Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 97,197

2007 Work RVU: 4.36 **2012 Work RVU:** 4.42
2007 NF PE RVU: 5.32 **2012 NF PE RVU:** 7.95
2007 Fac PE RVU: 3.02 **2012 Fac PE RVU:** 4.58

RUC Recommendation: 4.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

13122 **Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 16,519

2007 Work RVU: 1.44 **2012 Work RVU:** 1.44
2007 NF PE RVU: 1.48 **2012 NF PE RVU:** 1.81
2007 Fac PE RVU: 0.63 **2012 Fac PE RVU:** 0.84

RUC Recommendation: 1.44 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

13131 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 32,877

2007 Work RVU: 3.80 **2012 Work RVU:** 3.83
2007 NF PE RVU: 4.53 **2012 NF PE RVU:** 6.12
2007 Fac PE RVU: 2.74 **2012 Fac PE RVU:** 3.71

RUC Recommendation: 3.73 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13132 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 188,152

2007 Work RVU: 6.48 **2012 Work RVU:** 6.58
2007 NF PE RVU: 6.42 **2012 NF PE RVU:** 9.49
2007 Fac PE RVU: 4.38 **2012 Fac PE RVU:** 6.31

RUC Recommendation: 4.78 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

13133 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 11,022

2007 Work RVU: 2.19 **2012 Work RVU:** 2.19
2007 NF PE RVU: 1.72 **2012 NF PE RVU:** 2.40
2007 Fac PE RVU: 1.02 **2012 Fac PE RVU:** 1.38

RUC Recommendation: 2.19 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

13150 **Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,391

2007 Work RVU: 3.82 **2012 Work RVU:** 3.85
2007 NF PE RVU: 4.83 **2012 NF PE RVU:** 6.06
2007 Fac PE RVU: 2.76 **2012 Fac PE RVU:** 3.66

RUC Recommendation: Refer to CPT for Deletion **CPT Action (if applicable):** October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

13151 **Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 30,307

2007 Work RVU: 4.46 **2012 Work RVU:** 4.49
2007 NF PE RVU: 4.99 **2012 NF PE RVU:** 6.76
2007 Fac PE RVU: 3.17 **2012 Fac PE RVU:** 4.20

RUC Recommendation: 4.34 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13152 **Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 43,417

2007 Work RVU: 6.34 **2012 Work RVU:** 6.37
2007 NF PE RVU: 6.42 **2012 NF PE RVU:** 9.16
2007 Fac PE RVU: 4.03 **2012 Fac PE RVU:** 5.19

RUC Recommendation: 5.34 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13153 **Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.38 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

14000 **Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 10,319

2007 Work RVU: 6.83 **2012 Work RVU:** 6.37
2007 NF PE RVU: 8.14 **2012 NF PE RVU:** 10.93
2007 Fac PE RVU: 5.63 **2012 Fac PE RVU:** 7.49

RUC Recommendation: 6.19 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14001 **Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 9,240

2007 Work RVU: 9.60 **2012 Work RVU:** 8.78
2007 NF PE RVU: 9.86 **2012 NF PE RVU:** 13.35
2007 Fac PE RVU: 7.22 **2012 Fac PE RVU:** 9.23

RUC Recommendation: 8.58 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14020 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 23,697

2007 Work RVU: 7.66 **2012 Work RVU:** 7.22
2007 NF PE RVU: 8.98 **2012 NF PE RVU:** 12.24
2007 Fac PE RVU: 6.64 **2012 Fac PE RVU:** 8.59

RUC Recommendation: 7.02 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

14021 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 17,157

2007 Work RVU: 11.18 **2012 Work RVU:** 9.72
2007 NF PE RVU: 10.63 **2012 NF PE RVU:** 14.55
2007 Fac PE RVU: 8.41 **2012 Fac PE RVU:** 10.30

RUC Recommendation: 9.52 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

14040 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 81,330

2007 Work RVU: 8.44 **2012 Work RVU:** 8.6
2007 NF PE RVU: 9.17 **2012 NF PE RVU:** 12.73
2007 Fac PE RVU: 7.17 **2012 Fac PE RVU:** 9.10

RUC Recommendation: 8.44 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

14041 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 39,366

2007 Work RVU: 12.67 **2012 Work RVU:** 10.83
2007 NF PE RVU: 11.37 **2012 NF PE RVU:** 15.52
2007 Fac PE RVU: 8.88 **2012 Fac PE RVU:** 10.89

RUC Recommendation: 10.63 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14060 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 96,958

2007 Work RVU: 9.07 **2012 Work RVU:** 9.23
2007 NF PE RVU: 9.02 **2012 NF PE RVU:** 12.34
2007 Fac PE RVU: 7.39 **2012 Fac PE RVU:** 9.50

RUC Recommendation: 9.07 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

14061 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 25,460

2007 Work RVU: 13.67 **2012 Work RVU:** 11.48
2007 NF PE RVU: 12.45 **2012 NF PE RVU:** 16.83
2007 Fac PE RVU: 9.72 **2012 Fac PE RVU:** 11.73

RUC Recommendation: 11.25 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14300 **Deleted from CPT** **Global:** **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: 13.26 **2012 Work RVU:**
2007 NF PE RVU: 11.77 **2012 NF PE RVU:**
2007 Fac PE RVU: 9.28 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

14301 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm** **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 20,197

2007 Work RVU: **2012 Work RVU:** 12.65
2007 NF PE RVU: **2012 NF PE RVU:** 17.44
2007 Fac PE RVU: **2012 Fac PE RVU:** 11.84

RUC Recommendation: 12.47 **CPT Action (if applicable):** February 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14302 **Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 10,750

2007 Work RVU: **2012 Work RVU:** 3.73
2007 NF PE RVU: **2012 NF PE RVU:** 2.29
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.29

RUC Recommendation: 3.73 **CPT Action (if applicable):** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15120 **Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** Autograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 11,166

2007 Work RVU: 10.96 **2012 Work RVU:** 10.15
2007 NF PE RVU: 10.87 **2012 NF PE RVU:** 13.62
2007 Fac PE RVU: 7.71 **2012 Fac PE RVU:** 9.17

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

15170 **Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: 090 **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,547

2007 Work RVU: 5.99 **2012 Work RVU:**
2007 NF PE RVU: 3.79 **2012 NF PE RVU:**
2007 Fac PE RVU: 2.37 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15171 **Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,438

2007 Work RVU: 1.55 **2012 Work RVU:**
2007 NF PE RVU: 0.68 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.6 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15175 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children**

Global: 090 **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 2,011

2007 Work RVU: 7.99 **2012 Work RVU:**
2007 NF PE RVU: 5.4 **2012 NF PE RVU:**
2007 Fac PE RVU: 3.96 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 239

2007 Work RVU: 2.45 **2012 Work RVU:**
2007 NF PE RVU: 1.1 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.95 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15220 **Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less**

Global: 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 7,922

2007 Work RVU: 7.95 **2012 Work RVU:** 8.09
2007 NF PE RVU: 9.5 **2012 NF PE RVU:** 13.34
2007 Fac PE RVU: 6.69 **2012 Fac PE RVU:** 8.90

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.5
2007 NF PE RVU: **2012 NF PE RVU:** 2.49
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.83

RUC Recommendation: 1.50 **CPT Action (if applicable):** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.33
2007 NF PE RVU: **2012 NF PE RVU:** 0.43
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.14

RUC Recommendation: 0.59 **CPT Action (if applicable):** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.5
2007 NF PE RVU: **2012 NF PE RVU:** 4.59
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.03

RUC Recommendation: 3.50 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.8
2007 NF PE RVU: **2012 NF PE RVU:** 1.15
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.40

RUC Recommendation: 0.80 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.83
2007 NF PE RVU: **2012 NF PE RVU:** 2.41
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.85

RUC Recommendation: 1.83 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.5
2007 NF PE RVU: **2012 NF PE RVU:** 0.43
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.17

RUC Recommendation: 0.59 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4
2007 NF PE RVU: **2012 NF PE RVU:** 4.17
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.76

RUC Recommendation: 4.00 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1
2007 NF PE RVU: **2012 NF PE RVU:** 1.28
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.48

RUC Recommendation: 1.00 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15320 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 090 **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 2,098

2007 Work RVU: 5.36 **2012 Work RVU:**
2007 NF PE RVU: 3.66 **2012 NF PE RVU:**
2007 Fac PE RVU: 2.49 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15321 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,128

2007 Work RVU: 1.50 **2012 Work RVU:**
2007 NF PE RVU: 0.69 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.57 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15330 **Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children** **Global:** 090 **Issue:** Allograft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 3,696

2007 Work RVU: 3.99 **2012 Work RVU:**
2007 NF PE RVU: 3.18 **2012 NF PE RVU:**
2007 Fac PE RVU: 2.15 **2012 Fac PE RVU:**

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

15331 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,096

2007 Work RVU: 1.00 **2012 Work RVU:**
2007 NF PE RVU: 0.46 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.39 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15335 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 090 **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 1,754

2007 Work RVU: 4.50 **2012 Work RVU:**
2007 NF PE RVU: 3.46 **2012 NF PE RVU:**
2007 Fac PE RVU: 2.35 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15336 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 60

2007 Work RVU: 1.43 **2012 Work RVU:**
2007 NF PE RVU: 0.7 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.55 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15360 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 090 **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 899

2007 Work RVU: 3.93 **2012 Work RVU:**
2007 NF PE RVU: 4.47 **2012 NF PE RVU:**
2007 Fac PE RVU: 3.13 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15361 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 75

2007 Work RVU: 1.15 **2012 Work RVU:**
2007 NF PE RVU: 0.58 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.44 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15365 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 090 **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 37,408

2007 Work RVU: 4.21 **2012 Work RVU:**
2007 NF PE RVU: 4.5 **2012 NF PE RVU:**
2007 Fac PE RVU: 3.2 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15366 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 357

2007 Work RVU: 1.45 **2012 Work RVU:**
2007 NF PE RVU: 0.7 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.56 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15400 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 090 **Issue:** Xenograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAO-HNS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,220

2007 Work RVU: 4.38 **2012 Work RVU:**
2007 NF PE RVU: 4.25 **2012 NF PE RVU:**
2007 Fac PE RVU: 3.95 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15401 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Xenograft **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACS, ASPS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 6,008

2007 Work RVU: 1.00 **2012 Work RVU:**
2007 NF PE RVU: 1.67 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.42 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15420 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 090 **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** October 2009 **2010 Medicare Utilization Data:** 4,836

2007 Work RVU: 4.89 **2012 Work RVU:**
2007 NF PE RVU: 4.86 **2012 NF PE RVU:**
2007 Fac PE RVU: 3.83 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15421 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** ZZZ **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** February 2010 **2010 Medicare Utilization Data:** 643

2007 Work RVU: 1.50 **2012 Work RVU:**
2007 NF PE RVU: 1.29 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.6 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15570 **Formation of direct or tubed pedicle, with or without transfer; trunk** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 439

2007 Work RVU: 10.00 **2012 Work RVU:** 10.21
2007 NF PE RVU: 11.09 **2012 NF PE RVU:** 14.56
2007 Fac PE RVU: 6.71 **2012 Fac PE RVU:** 9.47

RUC Recommendation: 10.00 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15572 **Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 689

2007 Work RVU: 9.94 **2012 Work RVU:** 10.12
2007 NF PE RVU: 9.59 **2012 NF PE RVU:** 14.06
2007 Fac PE RVU: 6.53 **2012 Fac PE RVU:** 10.06

RUC Recommendation: 9.94 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15574 **Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,089

2007 Work RVU: 10.52 **2012 Work RVU:** 10.7
2007 NF PE RVU: 10.64 **2012 NF PE RVU:** 14.42
2007 Fac PE RVU: 7.6 **2012 Fac PE RVU:** 10.24

RUC Recommendation: 10.52 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15576 **Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,935

2007 Work RVU: 9.24 **2012 Work RVU:** 9.37
2007 NF PE RVU: 9.74 **2012 NF PE RVU:** 12.96
2007 Fac PE RVU: 6.81 **2012 Fac PE RVU:** 9.11

RUC Recommendation: 9.24 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15732 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)**

Global: 090 **Issue:** Muscle - Skin Graft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 16 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 13,118

2007 Work RVU: 19.70 **2012 Work RVU:** 16.38
2007 NF PE RVU: 17.27 **2012 NF PE RVU:** 19.46
2007 Fac PE RVU: 12.01 **2012 Fac PE RVU:** 14.71

RUC Recommendation: 19.83 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15740 **Flap; island pedicle**

Global: 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 28 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,635

2007 Work RVU: 11.57 **2012 Work RVU:** 11.8
2007 NF PE RVU: 11.01 **2012 NF PE RVU:** 16.51
2007 Fac PE RVU: 8.58 **2012 Fac PE RVU:** 11.97

RUC Recommendation: 11.57 **CPT Action (if applicable):** February 2009 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.65
2007 NF PE RVU: **2012 NF PE RVU:** 1.87
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.87

RUC Recommendation: 3.65 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15823 **Blepharoplasty, upper eyelid; with excessive skin weighting down lid**

Global: 090 **Issue:** Upper Eyelid Blepharoplasty **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 33 **Specialty Developing Recommendation:** AAO **First Identified:** October 2009 **2010 Medicare Utilization Data:** 103,401

2007 Work RVU: 8.12 **2012 Work RVU:** 6.81
2007 NF PE RVU: 7.8 **2012 NF PE RVU:** 10.05
2007 Fac PE RVU: 6.41 **2012 Fac PE RVU:** 8.30

RUC Recommendation: 6.81 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

16020 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 18,960

2007 Work RVU: 0.80 **2012 Work RVU:** 0.71
2007 NF PE RVU: 1.25 **2012 NF PE RVU:** 1.56
2007 Fac PE RVU: 0.58 **2012 Fac PE RVU:** 0.77

RUC Recommendation: 0.80 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

16025 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 2,479

2007 Work RVU: 1.85 **2012 Work RVU:** 1.74
2007 NF PE RVU: 1.72 **2012 NF PE RVU:** 2.27
2007 Fac PE RVU: 0.94 **2012 Fac PE RVU:** 1.26

RUC Recommendation: 1.85 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

16030 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACEP, ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,543

2007 Work RVU: 2.08 **2012 Work RVU:** 2.08
2007 NF PE RVU: 2.12 **2012 NF PE RVU:** 2.86
2007 Fac PE RVU: 1.08 **2012 Fac PE RVU:** 1.45

RUC Recommendation: CPT Assistant article **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Under development

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17000 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion**

Global: 010 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 4,800,111

2007 Work RVU: 0.62 **2012 Work RVU:** 0.65
2007 NF PE RVU: 1.08 **2012 NF PE RVU:** 1.65
2007 Fac PE RVU: 0.59 **2012 Fac PE RVU:** 0.92

RUC Recommendation: Survey for work and PE for January 2013 RUC meeting. **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17003 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)**

Global: ZZZ **Issue:** **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 15,161,441

2007 Work RVU: 0.07 **2012 Work RVU:** 0.07
2007 NF PE RVU: 0.11 **2012 NF PE RVU:** 0.13
2007 Fac PE RVU: 0.06 **2012 Fac PE RVU:** 0.05

RUC Recommendation: Survey for work and PE for January 2013 RUC meeting.

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17004 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

Global: 010 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 740,858

2007 Work RVU: 1.82 **2012 Work RVU:** 1.85
2007 NF PE RVU: 2.33 **2012 NF PE RVU:** 2.93
2007 Fac PE RVU: 1.54 **2012 Fac PE RVU:** 1.78

RUC Recommendation: Survey for work and PE for January 2013 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

17106 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2010 Medicare Utilization Data:** 2,498

2007 Work RVU: 4.62 **2012 Work RVU:** 3.69
2007 NF PE RVU: 4.63 **2012 NF PE RVU:** 5.83
2007 Fac PE RVU: 3.33 **2012 Fac PE RVU:** 3.90

RUC Recommendation: 3.61

CPT Action (if applicable):

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17107 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm** **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,613

2007 Work RVU: 9.19 **2012 Work RVU:** 4.79
2007 NF PE RVU: 7.24 **2012 NF PE RVU:** 7.43
2007 Fac PE RVU: 5.41 **2012 Fac PE RVU:** 4.89

RUC Recommendation: 4.68 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17108 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm** **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2010 Medicare Utilization Data:** 3,436

2007 Work RVU: 13.22 **2012 Work RVU:** 7.49
2007 NF PE RVU: 9.34 **2012 NF PE RVU:** 10.07
2007 Fac PE RVU: 7.49 **2012 Fac PE RVU:** 6.74

RUC Recommendation: 6.37 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17261 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm** **Global:** 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 131,848

2007 Work RVU: 1.19 **2012 Work RVU:** 1.22
2007 NF PE RVU: 1.84 **2012 NF PE RVU:** 2.84
2007 Fac PE RVU: 0.9 **2012 Fac PE RVU:** 1.32

RUC Recommendation: 1.22 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17262 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 202,301

2007 Work RVU: 1.60 **2012 Work RVU:** 1.63
2007 NF PE RVU: 2.13 **2012 NF PE RVU:** 3.29
2007 Fac PE RVU: 1.09 **2012 Fac PE RVU:** 1.59

RUC Recommendation: 1.63 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17271 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 57,313

2007 Work RVU: 1.51 **2012 Work RVU:** 1.54
2007 NF PE RVU: 2 **2012 NF PE RVU:** 3.05
2007 Fac PE RVU: 1.05 **2012 Fac PE RVU:** 1.53

RUC Recommendation: 1.54 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17272 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 71,623

2007 Work RVU: 1.79 **2012 Work RVU:** 1.82
2007 NF PE RVU: 2.24 **2012 NF PE RVU:** 3.41
2007 Fac PE RVU: 1.18 **2012 Fac PE RVU:** 1.72

RUC Recommendation: 1.82 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17281 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 130,602

2007 Work RVU: 1.74 **2012 Work RVU:** 1.77
2007 NF PE RVU: 2.12 **2012 NF PE RVU:** 3.21
2007 Fac PE RVU: 1.16 **2012 Fac PE RVU:** 1.68

RUC Recommendation: 1.77 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17282 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 107,468

2007 Work RVU: 2.06 **2012 Work RVU:** 2.09
2007 NF PE RVU: 2.41 **2012 NF PE RVU:** 3.63
2007 Fac PE RVU: 1.31 **2012 Fac PE RVU:** 1.89

RUC Recommendation: 2.09 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17311 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 514,703

2007 Work RVU: 6.20 **2012 Work RVU:** 6.2
2007 NF PE RVU: 10.79 **2012 NF PE RVU:** 12.43
2007 Fac PE RVU: 3.16 **2012 Fac PE RVU:** 4.17

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

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17312 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 397,870

2007 Work RVU: 3.30 **2012 Work RVU:** 3.3
2007 NF PE RVU: 6.92 **2012 NF PE RVU:** 7.90
2007 Fac PE RVU: 1.68 **2012 Fac PE RVU:** 2.22

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

17313 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 77,795

2007 Work RVU: 5.56 **2012 Work RVU:** 5.56
2007 NF PE RVU: 9.95 **2012 NF PE RVU:** 11.45
2007 Fac PE RVU: 2.83 **2012 Fac PE RVU:** 3.74

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

17314 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 42,948

2007 Work RVU: 3.06 **2012 Work RVU:** 3.06
2007 NF PE RVU: 6.41 **2012 NF PE RVU:** 7.32
2007 Fac PE RVU: 1.55 **2012 Fac PE RVU:** 2.06

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17315 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 22,459

2007 Work RVU: 0.87 **2012 Work RVU:** 0.87
2007 NF PE RVU: 1.15 **2012 NF PE RVU:** 1.35
2007 Fac PE RVU: 0.44 **2012 Fac PE RVU:** 0.59

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

19020 **Mastotomy with exploration or drainage of abscess, deep**

Global: 090 **Issue:** Mastotomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,989

2007 Work RVU: 3.74 **2012 Work RVU:** 3.83
2007 NF PE RVU: 6.39 **2012 NF PE RVU:** 9.05
2007 Fac PE RVU: 2.76 **2012 Fac PE RVU:** 4.24

RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

19295 **Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Image Guidance **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 131,626

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 2.57 **2012 NF PE RVU:** 2.67
2007 Fac PE RVU: 2.02 **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

19318 **Reduction mammaplasty** **Global:** 090 **Issue:** Mammaplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 6,937

2007 Work RVU: 15.91 **2012 Work RVU:** 16.03
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.94 **2012 Fac PE RVU:** 14.04

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

19340 **Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction** **Global:** 090 **Issue:** Insertion of Breast Prosthesis **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 10 **Specialty Developing Recommendation:** ASPS **First Identified:** **2010 Medicare Utilization Data:** 2,623

2007 Work RVU: 6.32 **2012 Work RVU:** 13.99
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.07 **2012 Fac PE RVU:** 11.36

RUC Recommendation: 13.99 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19357 **Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion** **Global:** 090 **Issue:** Breast Reconstruction **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 20 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,976

2007 Work RVU: 20.57 **2012 Work RVU:** 18.5
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 15.69 **2012 Fac PE RVU:** 22.67

RUC Recommendation: 18.50 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20000 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 010 **Issue:** Incision of Abcess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,753

2007 Work RVU: 2.14 **2012 Work RVU:**
2007 NF PE RVU: 2.71 **2012 NF PE RVU:**
2007 Fac PE RVU: 1.68 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** June 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20005 **Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)** **Global:** 010 **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,262

2007 Work RVU: 3.55 **2012 Work RVU:** 3.58
2007 NF PE RVU: 3.54 **2012 NF PE RVU:** 4.66
2007 Fac PE RVU: 2.2 **2012 Fac PE RVU:** 2.62

RUC Recommendation: 3.55 **CPT Action (if applicable):** June 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20525 **Removal of foreign body in muscle or tendon sheath; deep or complicated** **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,815

2007 Work RVU: 3.51 **2012 Work RVU:** 3.54
2007 NF PE RVU: 8.62 **2012 NF PE RVU:** 10.01
2007 Fac PE RVU: 2.52 **2012 Fac PE RVU:** 3.17

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

20550 **Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")** **Global:** 000 **Issue:** Tendon Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** APMA, AAPM, AAOS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 769,185

2007 Work RVU: 0.75 **2012 Work RVU:** 0.75
2007 NF PE RVU: 0.69 **2012 NF PE RVU:** 0.85
2007 Fac PE RVU: 0.25 **2012 Fac PE RVU:** 0.37

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

20551 **Injection(s); single tendon origin/insertion** **Global:** 000 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** APMA, AAPM, AAOS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 152,826

2007 Work RVU: 0.75 **2012 Work RVU:** 0.75
2007 NF PE RVU: 0.67 **2012 NF PE RVU:** 0.89
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.41

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20600 **Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 09 **Specialty Developing Recommendation:** AAOS, ACRh, APMA, ASSH, AOFAS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 396,910

2007 Work RVU: 0.66 **2012 Work RVU:** 0.66
2007 NF PE RVU: 0.66 **2012 NF PE RVU:** 0.86
2007 Fac PE RVU: 0.34 **2012 Fac PE RVU:** 0.40

RUC Recommendation: 0.66 and new PE inputs **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20605 **Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 09 **Specialty Developing Recommendation:** AAOS, ACRh, APMA, ASSH, AOFAS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 499,253

2007 Work RVU: 0.68 **2012 Work RVU:** 0.68
2007 NF PE RVU: 0.76 **2012 NF PE RVU:** 0.92
2007 Fac PE RVU: 0.35 **2012 Fac PE RVU:** 0.43

RUC Recommendation: 0.68 and new PE inputs **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20610 **Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 39 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 5,973,805

2007 Work RVU: 0.79 **2012 Work RVU:** 0.79
2007 NF PE RVU: 0.98 **2012 NF PE RVU:** 1.14
2007 Fac PE RVU: 0.42 **2012 Fac PE RVU:** 0.55

RUC Recommendation: 0.79 and new PE inputs **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20694 **Removal, under anesthesia, of external fixation system**

Global: 090 **Issue:** External Fixation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,351

2007 Work RVU: 4.20 **2012 Work RVU:** 4.28
2007 NF PE RVU: 6.69 **2012 NF PE RVU:** 7.42
2007 Fac PE RVU: 3.92 **2012 Fac PE RVU:** 4.86

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

20900 **Bone graft, any donor area; minor or small (eg, dowel or button)**

Global: 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,008

2007 Work RVU: 5.77 **2012 Work RVU:** 3
2007 NF PE RVU: 8.65 **2012 NF PE RVU:** 8.83
2007 Fac PE RVU: 5.5 **2012 Fac PE RVU:** 2.94

RUC Recommendation: 3.00 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20902 **Bone graft, any donor area; major or large**

Global: 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 3,879

2007 Work RVU: 7.98 **2012 Work RVU:** 4.58
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.63 **2012 Fac PE RVU:** 3.86

RUC Recommendation: 4.58 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20926 **Tissue grafts, other (eg, paratenon, fat, dermis)**

Global: 090 **Issue:** Tissue Grafts **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAOS, AAO-HNS, AANS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 14,944

2007 Work RVU: 5.70 **2012 Work RVU:** 5.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.67 **2012 Fac PE RVU:** 5.93

RUC Recommendation: Review October 2012 **CPT Action (if applicable):** October 2009 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21015 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS, AAO-HNS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,322

2007 Work RVU: 5.59 **2012 Work RVU:** 9.89
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.85 **2012 Fac PE RVU:** 8.57

RUC Recommendation: 9.71 **CPT Action (if applicable):** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

21025 **Excision of bone (eg, for osteomyelitis or bone abscess); mandible**

Global: 090 **Issue:** Excision of Bone – Mandible **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 61 **Specialty Developing Recommendation:** AAOMS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,407

2007 Work RVU: 11.07 **2012 Work RVU:** 10.03
2007 NF PE RVU: 12.32 **2012 NF PE RVU:** 14.64
2007 Fac PE RVU: 9.21 **2012 Fac PE RVU:** 10.56

RUC Recommendation: 10.03 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

21557 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,211

2007 Work RVU: 8.91 **2012 Work RVU:** 14.75
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.13 **2012 Fac PE RVU:** 9.86

RUC Recommendation: 14.57 **CPT Action (if applicable):** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

21935 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 822

2007 Work RVU: 18.38 **2012 Work RVU:** 15.72
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.37 **2012 Fac PE RVU:** 11.43

RUC Recommendation: 15.54 **CPT Action (if applicable):** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22214 **Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 2,051

2007 Work RVU: 20.77 **2012 Work RVU:** 21.02
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.53 **2012 Fac PE RVU:** 17.45

RUC Recommendation: Review September 2014 **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

22520 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic**

Global: 010 **Issue:** Moderate Sedation PE Inputs **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASNR, NASS, SIR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 11,422

2007 Work RVU: 9.17 **2012 Work RVU:** 9.22
2007 NF PE RVU: 56.83 **2012 NF PE RVU:** 55.91
2007 Fac PE RVU: 4.84 **2012 Fac PE RVU:** 4.78

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** February 2009 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

22521 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar**

Global: 010 **Issue:** Moderate Sedation PE Inputs **Screen:** Site of Service Anomaly (99238-Only); CMS Request - PE Inputs **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASNR, NASS, SIR **First Identified:** September 2007 **2010 Medicare Utilization Data:** 12,100

2007 Work RVU: 8.60 **2012 Work RVU:** 8.65
2007 NF PE RVU: 52.87 **2012 NF PE RVU:** 56.22
2007 Fac PE RVU: 4.69 **2012 Fac PE RVU:** 4.67

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** February 2009 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22523 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic**

Global: 010 **Issue:** Kyphoplasty **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 47 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** September 2011 **2010 Medicare Utilization Data:** 21,675

2007 Work RVU: 9.21 **2012 Work RVU:** 9.04
2007 NF PE RVU: NA **2012 NF PE RVU:** 214.36
2007 Fac PE RVU: 5.6 **2012 Fac PE RVU:** 5.97

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

22524 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar**

Global: 010 **Issue:** Kyphoplasty **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 47 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** September 2011 **2010 Medicare Utilization Data:** 24,197

2007 Work RVU: 8.81 **2012 Work RVU:** 8.54
2007 NF PE RVU: NA **2012 NF PE RVU:** 213.19
2007 Fac PE RVU: 5.4 **2012 Fac PE RVU:** 5.73

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

22525 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Kyphoplasty **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 47 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** September 2011 **2010 Medicare Utilization Data:** 12,010

2007 Work RVU: 4.47 **2012 Work RVU:** 4.47
2007 NF PE RVU: NA **2012 NF PE RVU:** 134.31
2007 Fac PE RVU: 2.12 **2012 Fac PE RVU:** 2.23

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22533 **Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 941

2007 Work RVU: 24.61 **2012 Work RVU:** 24.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.57 **2012 Fac PE RVU:** 18.39

RUC Recommendation: Remove from screen. CPT Assistant article published.

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

22551 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 25
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 18.46

RUC Recommendation: 24.50

CPT Action (if applicable): October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.5
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.41

RUC Recommendation: 6.50

CPT Action (if applicable): October 2009

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22554 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 34,259

2007 Work RVU: 17.54 **2012 Work RVU:** 17.69
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.97 **2012 Fac PE RVU:** 14.58

RUC Recommendation: 4.04 **CPT Action (if applicable):** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22585 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2010 Medicare Utilization Data:** 36,908

2007 Work RVU: 5.52 **2012 Work RVU:** 5.52
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.62 **2012 Fac PE RVU:** 2.90

RUC Recommendation: Remove from screen **CPT Action (if applicable):** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22612 **Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 65,834

2007 Work RVU: 23.38 **2012 Work RVU:** 23.53
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.83 **2012 Fac PE RVU:** 17.38

RUC Recommendation: Review 3/4 2012 utilization data at the RAW in January 2013. The specialty socieites ability to survey will change as surgeons are able to understand correct coding. 23.53 **CPT Action (if applicable):** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22614 **Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 99,337

2007 Work RVU: 6.43 **2012 Work RVU:** 6.43
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.15 **2012 Fac PE RVU:** 3.45

RUC Recommendation: 6.43 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22630 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 30,901

2007 Work RVU: 21.89 **2012 Work RVU:** 22.09
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.39 **2012 Fac PE RVU:** 17.26

RUC Recommendation: 22.09 **CPT Action (if applicable):** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22632 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 11,473

2007 Work RVU: 5.22 **2012 Work RVU:** 5.22
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.51 **2012 Fac PE RVU:** 2.79

RUC Recommendation: 5.22 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 27.75
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 19.69

RUC Recommendation: 27.75 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22634 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 8.16
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 4.37

RUC Recommendation: 8.16 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22843 **Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 4,101

2007 Work RVU: 13.44 **2012 Work RVU:** 13.44
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.28 **2012 Fac PE RVU:** 7.21

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22849 **Reinsertion of spinal fixation device** **Global:** 090 **Issue:** Spinal Fixation **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 3,836

2007 Work RVU: 19.08 **2012 Work RVU:** 19.17
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.39 **2012 Fac PE RVU:** 14.16

RUC Recommendation: Review September 2014 **CPT Action (if applicable):** June 2010 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

22851 **Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Intervertebral Device **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 93,182

2007 Work RVU: 6.70 **2012 Work RVU:** 6.7
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.18 **2012 Fac PE RVU:** 3.57

RUC Recommendation: Review utilization data at the RAW as part of the re-review of this service under the CMS Fastest Growing screen. **CPT Action (if applicable):** October 2009 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

22900 **Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm** **Global:** 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,471

2007 Work RVU: 6.14 **2012 Work RVU:** 8.32
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.3 **2012 Fac PE RVU:** 6.07

RUC Recommendation: 8.21 **CPT Action (if applicable):** June 2008 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23076 **Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,009

2007 Work RVU: 7.77 **2012 Work RVU:** 7.41
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.5 **2012 Fac PE RVU:** 6.99

RUC Recommendation: 7.28 **CPT Action (if applicable):** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23120 **Claviculectomy; partial**

Global: 090 **Issue:** Claviculectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 30 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 12,943

2007 Work RVU: 7.23 **2012 Work RVU:** 7.39
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.22 **2012 Fac PE RVU:** 8.28

RUC Recommendation: 7.23 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

23130 **Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release**

Global: 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,827

2007 Work RVU: 7.63 **2012 Work RVU:** 7.77
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.88 **2012 Fac PE RVU:** 8.52

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

23350 **Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography**

Global: 000 **Issue:** Injection for Shoulder X-Ray **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 32,653

2007 Work RVU: 1.00 **2012 Work RVU:** 1
2007 NF PE RVU: 3.23 **2012 NF PE RVU:** 3.23
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.39

RUC Recommendation: 1.00 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23405 **Tenotomy, shoulder area; single tendon** **Global:** 090 **Issue:** Tenotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,512

2007 Work RVU: 8.43 **2012 Work RVU:** 8.54
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.69 **2012 Fac PE RVU:** 8.25

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23410 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,930

2007 Work RVU: 12.63 **2012 Work RVU:** 11.39
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.02 **2012 Fac PE RVU:** 10.56

RUC Recommendation: 11.23 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23412 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 22,578

2007 Work RVU: 13.55 **2012 Work RVU:** 11.93
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.49 **2012 Fac PE RVU:** 10.87

RUC Recommendation: 11.77 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23415 **Coracoacromial ligament release, with or without acromioplasty** **Global:** 090 **Issue:** Shoulder Ligament Release **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 62 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,236

2007 Work RVU: 10.09 **2012 Work RVU:** 9.23
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.65 **2012 Fac PE RVU:** 9.35

RUC Recommendation: 9.23 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23420 **Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)**

Global: 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 9,620

2007 Work RVU: 14.75 **2012 Work RVU:** 13.54
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.59 **2012 Fac PE RVU:** 12.31

RUC Recommendation: 13.35 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23430 **Tenodesis of long tendon of biceps**

Global: 090 **Issue:** Tenodesis **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 8,515

2007 Work RVU: 10.05 **2012 Work RVU:** 10.17
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.78 **2012 Fac PE RVU:** 9.78

RUC Recommendation: 10.17 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

23440 **Resection or transplantation of long tendon of biceps**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,849

2007 Work RVU: 10.53 **2012 Work RVU:** 10.64
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.91 **2012 Fac PE RVU:** 9.51

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23472 **Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))**

Global: 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 24,416

2007 Work RVU: 22.47 **2012 Work RVU:** 22.65
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.89 **2012 Fac PE RVU:** 16.97

RUC Recommendation: Remove from screen **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Remove from Screen

23600 **Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation**

Global: 090 **Issue:** Treatment of Humerus Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 14 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 36,584

2007 Work RVU: 3.00 **2012 Work RVU:** 3.11
2007 NF PE RVU: 4.43 **2012 NF PE RVU:** 5.72
2007 Fac PE RVU: 3.58 **2012 Fac PE RVU:** 5.09

RUC Recommendation: 3.00 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

25116 **Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum**

Global: 090 **Issue:** Forearm Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 63 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,040

2007 Work RVU: 7.38 **2012 Work RVU:** 7.56
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.13 **2012 Fac PE RVU:** 9.15

RUC Recommendation: 7.56 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

25210 **Carpectomy; 1 bone** **Global:** 090 **Issue:** Carpectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,707

2007 Work RVU: 6.01 **2012 Work RVU:** 6.12
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.49 **2012 Fac PE RVU:** 7.19

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: PE Only

25260 **Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,192

2007 Work RVU: 7.89 **2012 Work RVU:** 8.04
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.3 **2012 Fac PE RVU:** 9.43

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: PE Only

25280 **Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,475

2007 Work RVU: 7.28 **2012 Work RVU:** 7.39
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.6 **2012 Fac PE RVU:** 8.32

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: PE Only

25310 **Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon** **Global:** 090 **Issue:** Forearm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 15 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 7,273

2007 Work RVU: 8.26 **2012 Work RVU:** 8.08
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.99 **2012 Fac PE RVU:** 9.12

RUC Recommendation: 7.94 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

26080 **Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each**

Global: 090 **Issue:** Finger Arthrotomy **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,641

2007 Work RVU: 4.36 **2012 Work RVU:** 4.47
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.73 **2012 Fac PE RVU:** 6.11

RUC Recommendation: CPT Assistant Article and Re-review October 2012.

CPT Action (if applicable):
Referred to CPT Asst ☑ **Published in CPT Asst:**

Result:

26356 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,138

2007 Work RVU: 10.22 **2012 Work RVU:** 10.62
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 17.22 **2012 Fac PE RVU:** 19.40

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

26480 **Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon**

Global: 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2010 Medicare Utilization Data:** 4,614

2007 Work RVU: 6.76 **2012 Work RVU:** 6.9
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.68 **2012 Fac PE RVU:** 13.91

RUC Recommendation: 6.76

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

27048 **Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 05 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 579

2007 Work RVU: 6.44 **2012 Work RVU:** 8.85
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.76 **2012 Fac PE RVU:** 7.03

RUC Recommendation: 8.74

CPT Action (if applicable): June 2008
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

27062 **Excision; trochanteric bursa or calcification** **Global:** 090 **Issue:** Trochanteric Bursa Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 32 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,297

2007 Work RVU: 5.66 **2012 Work RVU:** 5.75
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.05 **2012 Fac PE RVU:** 6.45

RUC Recommendation: 5.66 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27096 **Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed** **Global:** 000 **Issue:** Injection for Sacroiliac Joint **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 06 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 301,238

2007 Work RVU: 1.40 **2012 Work RVU:** 1.48
2007 NF PE RVU: 3.88 **2012 NF PE RVU:** 3.43
2007 Fac PE RVU: 0.33 **2012 Fac PE RVU:** 0.80

RUC Recommendation: 1.48 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27130 **Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft** **Global:** 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 113,828

2007 Work RVU: 21.61 **2012 Work RVU:** 21.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.96 **2012 Fac PE RVU:** 16.39

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting. **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27236 **Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 66,351

2007 Work RVU: 17.43 **2012 Work RVU:** 17.61
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.85 **2012 Fac PE RVU:** 14.10

RUC Recommendation: Survey for work and PE for October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

27244 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 21,789

2007 Work RVU: 17.08 **2012 Work RVU:** 18.18
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.91 **2012 Fac PE RVU:** 14.43

RUC Recommendation: 18.00

CPT Action (if applicable):

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

27245 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 71,936

2007 Work RVU: 21.09 **2012 Work RVU:** 18.18
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.19 **2012 Fac PE RVU:** 14.63

RUC Recommendation: 18.00

CPT Action (if applicable):

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27250 **Closed treatment of hip dislocation, traumatic; without anesthesia** **Global:** 000 **Issue:** Closed Treatment of Hip Dislocation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 18 **Specialty Developing Recommendation:** ACEP **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,120

2007 Work RVU: 7.21 **2012 Work RVU:** 3.82
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.54 **2012 Fac PE RVU:** 1.19

RUC Recommendation: 3.82 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27324 **Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)** **Global:** 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 931

2007 Work RVU: 4.95 **2012 Work RVU:** 5.04
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.1 **2012 Fac PE RVU:** 5.37

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27370 **Injection procedure for knee arthrography** **Global:** 000 **Issue:** Injection for Knee Arthrography **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 21,440

2007 Work RVU: 0.96 **2012 Work RVU:** 0.96
2007 NF PE RVU: 3.47 **2012 NF PE RVU:** 3.97
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.46

RUC Recommendation: CPT Assistant Article **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** ACR clinical examp

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Status Report: CMS Requests and Relativity Assessment Issues

27447 **Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 270,073

2007 Work RVU: 23.04 **2012 Work RVU:** 23.25
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 14.14 **2012 Fac PE RVU:** 17.55

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable): **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

27615 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm**

Global: 090 **Issue:** Radical Resecion of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 694

2007 Work RVU: 12.93 **2012 Work RVU:** 15.72
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.07 **2012 Fac PE RVU:** 11.28

RUC Recommendation: 15.54

CPT Action (if applicable): June 2008 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

27619 **Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 799

2007 Work RVU: 8.47 **2012 Work RVU:** 6.91
2007 NF PE RVU: 9.65 **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.79 **2012 Fac PE RVU:** 6.21

RUC Recommendation: 6.80

CPT Action (if applicable): June 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27640 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,499

2007 Work RVU: 12.10 **2012 Work RVU:** 12.24
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.79 **2012 Fac PE RVU:** 10.32

RUC Recommendation: 12.10

CPT Action (if applicable): June 2008 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27641 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 821

2007 Work RVU: 9.73 **2012 Work RVU:** 9.84
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.96 **2012 Fac PE RVU:** 8.29

RUC Recommendation: 9.72 **CPT Action (if applicable):** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27650 **Repair, primary, open or percutaneous, ruptured Achilles tendon;**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,901

2007 Work RVU: 9.94 **2012 Work RVU:** 9.21
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.22 **2012 Fac PE RVU:** 8.91

RUC Recommendation: 9.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27654 **Repair, secondary, Achilles tendon, with or without graft**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,663

2007 Work RVU: 10.32 **2012 Work RVU:** 10.53
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.86 **2012 Fac PE RVU:** 8.82

RUC Recommendation: 10.32 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27685 **Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,481

2007 Work RVU: 6.57 **2012 Work RVU:** 6.69
2007 NF PE RVU: 7.68 **2012 NF PE RVU:** 11.62
2007 Fac PE RVU: 5.26 **2012 Fac PE RVU:** 6.07

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27687 **Gastrocnemius recession (eg, Strayer procedure)** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,762

2007 Work RVU: 6.30 **2012 Work RVU:** 6.41
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.12 **2012 Fac PE RVU:** 6.05

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: PE Only

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,847

2007 Work RVU: 8.96 **2012 Work RVU:** 9.17
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.15 **2012 Fac PE RVU:** 8.11

RUC Recommendation: 8.96 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,022

2007 Work RVU: 10.28 **2012 Work RVU:** 10.49
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.51 **2012 Fac PE RVU:** 9.80

RUC Recommendation: 10.28 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

27792 **Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed**

Global: 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, **First Identified:** June 2010 **2010 Medicare Utilization Data:** 6,387

2007 Work RVU: 7.91 **2012 Work RVU:** 8.75
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.71 **2012 Fac PE RVU:** 8.88

RUC Recommendation: 9.71 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27818 **Closed treatment of trimalleolar ankle fracture; with manipulation**

Global: 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,091

2007 Work RVU: 5.57 **2012 Work RVU:** 5.69
2007 NF PE RVU: 6.14 **2012 NF PE RVU:** 7.47
2007 Fac PE RVU: 5 **2012 Fac PE RVU:** 6.06

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28111 **Ostectomy, complete excision; first metatarsal head**

Global: 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,002

2007 Work RVU: 5.06 **2012 Work RVU:** 5.15
2007 NF PE RVU: 6.55 **2012 NF PE RVU:** 9.05
2007 Fac PE RVU: 3.58 **2012 Fac PE RVU:** 4.06

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28118 **Ostectomy, calcaneus;**

Global: 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,951

2007 Work RVU: 6.02 **2012 Work RVU:** 6.13
2007 NF PE RVU: 6.68 **2012 NF PE RVU:** 10.35
2007 Fac PE RVU: 4.28 **2012 Fac PE RVU:** 5.24

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28120 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,402

2007 Work RVU: 5.64 **2012 Work RVU:** 7.31
2007 NF PE RVU: 7.5 **2012 NF PE RVU:** 11.30
2007 Fac PE RVU: 4.31 **2012 Fac PE RVU:** 6.09

RUC Recommendation: 8.27 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28122 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 11,673

2007 Work RVU: 7.56 **2012 Work RVU:** 6.76
2007 NF PE RVU: 7.27 **2012 NF PE RVU:** 10.27
2007 Fac PE RVU: 5.17 **2012 Fac PE RVU:** 5.69

RUC Recommendation: 7.72 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28124 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe**

Global: 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 14,081

2007 Work RVU: 4.88 **2012 Work RVU:** 5
2007 NF PE RVU: 5.46 **2012 NF PE RVU:** 8.44
2007 Fac PE RVU: 3.62 **2012 Fac PE RVU:** 4.28

RUC Recommendation: Remove 99238 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28285 **Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)**

Global: 090 **Issue:** Orthopaedic Surgery/Podiatry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 31 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 85,690

2007 Work RVU: 4.65 **2012 Work RVU:** 5.62
2007 NF PE RVU: 5.34 **2012 NF PE RVU:** 9.16
2007 Fac PE RVU: 3.42 **2012 Fac PE RVU:** 4.73

RUC Recommendation: 5.62 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28296 **Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)**

Global: 090 **Issue:** Hallus Valgus Correction **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 23 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 17,220

2007 Work RVU: 9.31 **2012 Work RVU:** 8.35
2007 NF PE RVU: 8.54 **2012 NF PE RVU:** 11.81
2007 Fac PE RVU: 5.29 **2012 Fac PE RVU:** 6.26

RUC Recommendation: 8.16 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28298 **Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy**

Global: 090 **Issue:** Correction of Bunion **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,409

2007 Work RVU: 8.01 **2012 Work RVU:** 8.13
2007 NF PE RVU: 7.74 **2012 NF PE RVU:** 11.94
2007 Fac PE RVU: 4.91 **2012 Fac PE RVU:** 5.83

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28300 **Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,263

2007 Work RVU: 9.61 **2012 Work RVU:** 9.73
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.81 **2012 Fac PE RVU:** 8.08

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28310 **Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,214

2007 Work RVU: 5.48 **2012 Work RVU:** 5.57
2007 NF PE RVU: 6.2 **2012 NF PE RVU:** 9.59
2007 Fac PE RVU: 3.53 **2012 Fac PE RVU:** 4.28

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28470 **Closed treatment of metatarsal fracture; without manipulation, each**

Global: 090 **Issue:** Treatment of Metatarsal Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 15 **Specialty Developing Recommendation:** AAOS, APMA, AOFAS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 39,926

2007 Work RVU: 1.99 **2012 Work RVU:** 2.03
2007 NF PE RVU: 3.05 **2012 NF PE RVU:** 3.85
2007 Fac PE RVU: 2.43 **2012 Fac PE RVU:** 3.23

RUC Recommendation: 2.03 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28725 **Arthrodesis; subtalar**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,928

2007 Work RVU: 11.97 **2012 Work RVU:** 11.22
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.93 **2012 Fac PE RVU:** 9.70

RUC Recommendation: 12.18 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28730 **Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,985

2007 Work RVU: 12.21 **2012 Work RVU:** 10.7
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 8.32 **2012 Fac PE RVU:** 9.52

RUC Recommendation: 12.42 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28740 **Arthrodesis, midtarsal or tarsometatarsal, single joint** **Global:** 090 **Issue:** Arthrodesis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,366

2007 Work RVU: 9.09 **2012 Work RVU:** 9.29
2007 NF PE RVU: 10.89 **2012 NF PE RVU:** 14.44
2007 Fac PE RVU: 6.37 **2012 Fac PE RVU:** 7.86

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28825 **Amputation, toe; interphalangeal joint** **Global:** 090 **Issue:** Partial Amputation of Toe **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 21 **Specialty Developing Recommendation:** AOFAS, ACS, APMA, AAOS, SVS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 9,855

2007 Work RVU: 3.71 **2012 Work RVU:** 5.37
2007 NF PE RVU: 7.04 **2012 NF PE RVU:** 10.06
2007 Fac PE RVU: 3.4 **2012 Fac PE RVU:** 5.00

RUC Recommendation: 6.01 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

29075 **Application, cast; elbow to finger (short arm)** **Global:** 000 **Issue:** Applicatoin of Forearm Cast **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 16 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** April 2011 **2010 Medicare Utilization Data:** 72,132

2007 Work RVU: 0.77 **2012 Work RVU:** 0.77
2007 NF PE RVU: 1.25 **2012 NF PE RVU:** 1.72
2007 Fac PE RVU: 0.68 **2012 Fac PE RVU:** 0.92

RUC Recommendation: 0.77 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29220 **Deleted from CPT** **Global:** **Issue:** Strapping; low back **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAFP **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.64 **2012 Work RVU:**
2007 NF PE RVU: 0.69 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT,

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Status Report: CMS Requests and Relativity Assessment Issues

29540 **Strapping; ankle and/or foot**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 34 **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 301,288

2007 Work RVU: 0.51 **2012 Work RVU:** 0.39
2007 NF PE RVU: 0.45 **2012 NF PE RVU:** 0.65
2007 Fac PE RVU: 0.31 **2012 Fac PE RVU:** 0.35

RUC Recommendation: 0.39 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29550 **Strapping; toes**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 34 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 83,230

2007 Work RVU: 0.47 **2012 Work RVU:** 0.25
2007 NF PE RVU: 0.46 **2012 NF PE RVU:** 0.64
2007 Fac PE RVU: 0.29 **2012 Fac PE RVU:** 0.32

RUC Recommendation: 0.25 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29590 **Denis-Browne splint strapping**

Global: 000 **Issue:** Dennis-Browne splint revision **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,932

2007 Work RVU: 0.76 **2012 Work RVU:** 0.76
2007 NF PE RVU: 0.54 **2012 NF PE RVU:** 0.73
2007 Fac PE RVU: 0.29 **2012 Fac PE RVU:** 0.30

RUC Recommendation: Refer to CPT for deletion **CPT Action (if applicable):** February 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

29805 **Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2010 Medicare Utilization Data:** 889

2007 Work RVU: 5.94 **2012 Work RVU:** 6.03
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.44 **2012 Fac PE RVU:** 6.63

RUC Recommendation: No NF PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29822 **Arthroscopy, shoulder, surgical; debridement, limited** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 10,580

2007 Work RVU: 7.49 **2012 Work RVU:** 7.6
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.43 **2012 Fac PE RVU:** 7.82

RUC Recommendation: Remove from screen **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Remove from Screen

29824 **Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)** **Global:** 090 **Issue:** Arthroscopy **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 45 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 35,576

2007 Work RVU: 8.82 **2012 Work RVU:** 8.98
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.3 **2012 Fac PE RVU:** 9.16

RUC Recommendation: 8.82 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

29826 **Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Arthroscopy **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 77,344

2007 Work RVU: 9.05 **2012 Work RVU:** 3
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.21 **2012 Fac PE RVU:** 1.65

RUC Recommendation: 3.00 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

29827 **Arthroscopy, shoulder, surgical; with rotator cuff repair**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Fastest Growing/ Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 45 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 47,064

2007 Work RVU: 15.44 **2012 Work RVU:** 15.59
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.01 **2012 Fac PE RVU:** 13.06

RUC Recommendation: 15.59 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29828 **Arthroscopy, shoulder, surgical; biceps tenodesis**

Global: 090 **Issue:** Arthroscopy **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 45 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 6,927

2007 Work RVU: **2012 Work RVU:** 13.16
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 11.38

RUC Recommendation: 13.16 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29830 **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2010 Medicare Utilization Data:** 94

2007 Work RVU: 5.80 **2012 Work RVU:** 5.88
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.14 **2012 Fac PE RVU:** 6.29

RUC Recommendation: No NF PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29840 **Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2010 Medicare Utilization Data:** 115

2007 Work RVU: 5.59 **2012 Work RVU:** 5.68
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.16 **2012 Fac PE RVU:** 6.55

RUC Recommendation: No NF PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29870 **Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 13 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2010 Medicare Utilization Data:** 1,783

2007 Work RVU: 5.11 **2012 Work RVU:** 5.19
2007 NF PE RVU: NA **2012 NF PE RVU:** 11.16
2007 Fac PE RVU: 4.72 **2012 Fac PE RVU:** 5.88

RUC Recommendation: New PE non-facility inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29888 **Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction**

Global: 090 **Issue:** ACL Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,699

2007 Work RVU: 14.14 **2012 Work RVU:** 14.3
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.75 **2012 Fac PE RVU:** 12.03

RUC Recommendation: 14.14 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29900 **Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2010 Medicare Utilization Data:** 3

2007 Work RVU: 5.74 **2012 Work RVU:** 5.88
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.6 **2012 Fac PE RVU:** 7.49

RUC Recommendation: No NF PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

30465 **Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)** **Global:** 090 **Issue:** Repair Nasal Stenosis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,582

2007 Work RVU: 12.20 **2012 Work RVU:** 12.36
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.58 **2012 Fac PE RVU:** 15.21

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

30901 **Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method** **Global:** 000 **Issue:** Control Nasal Hemorrhage **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 35 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 115,779

2007 Work RVU: 1.21 **2012 Work RVU:** 1.1
2007 NF PE RVU: 1.32 **2012 NF PE RVU:** 1.60
2007 Fac PE RVU: 0.31 **2012 Fac PE RVU:** 0.42

RUC Recommendation: 1.21 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31231 **Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)** **Global:** 000 **Issue:** Diagnostic Nasal Endoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2010 **2010 Medicare Utilization Data:** 390,494

2007 Work RVU: 1.10 **2012 Work RVU:** 1.1
2007 NF PE RVU: 3.37 **2012 NF PE RVU:** 4.57
2007 Fac PE RVU: 0.84 **2012 Fac PE RVU:** 1.07

RUC Recommendation: 1.10 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31237 **Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)** **Global:** 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 87,501

2007 Work RVU: 2.98 **2012 Work RVU:** 2.98
2007 NF PE RVU: 5.03 **2012 NF PE RVU:** 6.42
2007 Fac PE RVU: 1.72 **2012 Fac PE RVU:** 2.06

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31238 **Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 25,127

2007 Work RVU: 3.26 **2012 Work RVU:** 3.26
2007 NF PE RVU: 5.04 **2012 NF PE RVU:** 6.37
2007 Fac PE RVU: 1.9 **2012 Fac PE RVU:** 2.21

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

31239 **Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy**

Global: 010 **Issue:** **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 1,081

2007 Work RVU: 9.23 **2012 Work RVU:** 9.33
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.59 **2012 Fac PE RVU:** 9.63

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

31240 **Nasal/sinus endoscopy, surgical; with concha bullosa resection**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 3,554

2007 Work RVU: 2.61 **2012 Work RVU:** 2.61
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.59 **2012 Fac PE RVU:** 1.87

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

31571 **Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope**

Global: 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,323

2007 Work RVU: 4.26 **2012 Work RVU:** 4.26
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.36 **2012 Fac PE RVU:** 2.72

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

31575 **Laryngoscopy, flexible fiberoptic; diagnostic**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 576,744

2007 Work RVU: 1.10 **2012 Work RVU:** 1.1
2007 NF PE RVU: 1.82 **2012 NF PE RVU:** 2.22
2007 Fac PE RVU: 0.84 **2012 Fac PE RVU:** 1.06

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31579 **Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy**

Global: 000 **Issue:** Laryngoscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 52,389

2007 Work RVU: 2.26 **2012 Work RVU:** 2.26
2007 NF PE RVU: 3.5 **2012 NF PE RVU:** 3.85
2007 Fac PE RVU: 1.37 **2012 Fac PE RVU:** 1.68

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

31611 **Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)**

Global: 090 **Issue:** Speech Prosthesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 887

2007 Work RVU: 5.92 **2012 Work RVU:** 6
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.92 **2012 Fac PE RVU:** 9.45

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

32420 **Pneumocentesis, puncture of lung for aspiration**

Global: 000 **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 409

2007 Work RVU: 2.18 **2012 Work RVU:** 2.18
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.66 **2012 Fac PE RVU:** 0.81

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32421 **Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent**

Global: 000 **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 100,681

2007 Work RVU: **2012 Work RVU:** 1.54
2007 NF PE RVU: **2012 NF PE RVU:** 2.83
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.56

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

32422 **Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)**

Global: 000 **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 123,629

2007 Work RVU: **2012 Work RVU:** 2.19
2007 NF PE RVU: **2012 NF PE RVU:** 3.30
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.20

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

32440 **Removal of lung, pneumonectomy;**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2010 Medicare Utilization Data:** 713

2007 Work RVU: 27.17 **2012 Work RVU:** 27.28
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.44 **2012 Fac PE RVU:** 13.68

RUC Recommendation: Request further information from CMS **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32480 **Removal of lung, other than pneumonectomy; single lobe (lobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: November 2011 **2010 Medicare Utilization Data:** 11,086

2007 Work RVU: 25.71 **2012 Work RVU:** 25.82

2007 NF PE RVU: NA **2012 NF PE RVU:** NA

2007 Fac PE RVU: 11.63 **2012 Fac PE RVU:** 12.87

RUC Recommendation: Request further information from CMS

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

32482 **Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: November 2011 **2010 Medicare Utilization Data:** 788

2007 Work RVU: 27.28 **2012 Work RVU:** 27.44

2007 NF PE RVU: NA **2012 NF PE RVU:** NA

2007 Fac PE RVU: 12.48 **2012 Fac PE RVU:** 14.02

RUC Recommendation: Request further information from CMS

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

32491 **Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: November 2011 **2010 Medicare Utilization Data:** 97

2007 Work RVU: 25.09 **2012 Work RVU:** 25.24

2007 NF PE RVU: NA **2012 NF PE RVU:** NA

2007 Fac PE RVU: 12.13 **2012 Fac PE RVU:** 13.41

RUC Recommendation: Request further information from CMS

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32551 **Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)**

Global: 000 **Issue:** Chest Tube Thoracostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 10 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 63,483

2007 Work RVU: **2012 Work RVU:** 3.29
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.25

RUC Recommendation: 3.50 **CPT Action (if applicable):** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

32554 **Thoracocentesis, needle or catheter, aspiration of the pleural space; without imaging guidance**

Global: **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 11 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.54 (Interim) **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

32555 **Thoracocentesis, needle or catheter, aspiration of the pleural space; with imaging guidance**

Global: **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 11 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.21 (Interim) **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32556 **Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance**

Global: **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 11 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.19 (Interim) **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

32557 **Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance**

Global: **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 11 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 3.35 (Interim) **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

32663 **Thoracoscopy, surgical; with lobectomy (single lobe)**

Global: 090 **Issue:** Thoracoscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** STS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 4,969

2007 Work RVU: 24.56 **2012 Work RVU:** 24.64
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.44 **2012 Fac PE RVU:** 11.90

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

33207 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 24,763

2007 Work RVU: 9.05 **2012 Work RVU:** 8.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.95 **2012 Fac PE RVU:** 4.77

RUC Recommendation: 8.05 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33208 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 119,990

2007 Work RVU: 8.12 **2012 Work RVU:** 8.77
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.95 **2012 Fac PE RVU:** 5.07

RUC Recommendation: 8.77 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33212 **Insertion of pacemaker pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 11,161

2007 Work RVU: 5.51 **2012 Work RVU:** 5.26
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.46 **2012 Fac PE RVU:** 3.56

RUC Recommendation: 5.26 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33213 **Insertion of pacemaker pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:** 47,249

2007 Work RVU: 6.36 **2012 Work RVU:** 5.53
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.87 **2012 Fac PE RVU:** 3.76

RUC Recommendation: 5.53 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33221 **Insertion of pacemaker pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.8
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.43

RUC Recommendation: 5.80 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33227 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.5
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.31

RUC Recommendation: 5.50 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33228 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.77
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.41

RUC Recommendation: 5.77 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33229 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.04
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.51

RUC Recommendation: 6.04 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33230 **Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.32
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.59

RUC Recommendation: 6.32 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33231 **Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.59
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.69

RUC Recommendation: 6.59 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33233 **Removal of permanent pacemaker pulse generator only** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 62,644

2007 Work RVU: 3.33 **2012 Work RVU:** 3.39
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.29 **2012 Fac PE RVU:** 3.03

RUC Recommendation: 3.39 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33240 **Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 39,134

2007 Work RVU: 7.61 **2012 Work RVU:** 6.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.79 **2012 Fac PE RVU:** 4.17

RUC Recommendation: 6.06 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33241 **Removal of pacing cardioverter-defibrillator pulse generator only** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 46,631

2007 Work RVU: 3.26 **2012 Work RVU:** 3.29
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.99 **2012 Fac PE RVU:** 2.71

RUC Recommendation: 3.29 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33249 **Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 59,749

2007 Work RVU: 15.02 **2012 Work RVU:** 15.17
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 8.89 **2012 Fac PE RVU:** 8.70

RUC Recommendation: 15.17 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33262 **Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.06
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.50

RUC Recommendation: 6.06 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33263 **Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system** **Global:** 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.33
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.60

RUC Recommendation: 6.33 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33264 **Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.6
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.70

RUC Recommendation: 6.60 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33405 **Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 31,095

2007 Work RVU: 41.19 **2012 Work RVU:** 41.32
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 17.58 **2012 Fac PE RVU:** 18.47

RUC Recommendation: 41.32 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33430 **Replacement, mitral valve, with cardiopulmonary bypass**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** High IWPUT / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 8,309

2007 Work RVU: 50.75 **2012 Work RVU:** 50.93
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 17.71 **2012 Fac PE RVU:** 22.27

RUC Recommendation: 50.93 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33533 **Coronary artery bypass, using arterial graft(s); single arterial graft**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS **First Identified:** September 2011 **2010 Medicare Utilization Data:** 74,561

2007 Work RVU: 33.64 **2012 Work RVU:** 33.75
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 15.55 **2012 Fac PE RVU:** 15.42

RUC Recommendation: 34.98 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33863 **Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)**

Global: 090 **Issue:** Aortic Graft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,605

2007 Work RVU: 58.71 **2012 Work RVU:** 58.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 19.01 **2012 Fac PE RVU:** 23.06

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

35301 **Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 56,899

2007 Work RVU: 19.53 **2012 Work RVU:** 19.61
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 8.04 **2012 Fac PE RVU:** 8.51

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

35454 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 2,140

2007 Work RVU: 6.03 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 2.19 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35456 **Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 2,506

2007 Work RVU: 7.34 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 2.64 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35459 **Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 927

2007 Work RVU: 8.62 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 3.01 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35470 **Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 37,451

2007 Work RVU: 8.62 **2012 Work RVU:**
2007 NF PE RVU: 81.78 **2012 NF PE RVU:**
2007 Fac PE RVU: 3.37 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35471 **Transluminal balloon angioplasty, percutaneous; renal or visceral artery** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 10,417

2007 Work RVU: 10.05 **2012 Work RVU:** 10.05
2007 NF PE RVU: 91.6 **2012 NF PE RVU:** 70.27
2007 Fac PE RVU: 4.13 **2012 Fac PE RVU:** 4.17

RUC Recommendation: Remove from screen **CPT Action (if applicable):** Removed from CPT referral **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35472 **Transluminal balloon angioplasty, percutaneous; aortic**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 901

2007 Work RVU: 6.90 **2012 Work RVU:** 6.9
2007 NF PE RVU: 60.05 **2012 NF PE RVU:** 52.86
2007 Fac PE RVU: 2.75 **2012 Fac PE RVU:** 2.79

RUC Recommendation: Remove from screen **CPT Action (if applicable):** Removed from CPT referral **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

35473 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 27,510

2007 Work RVU: 6.03 **2012 Work RVU:**
2007 NF PE RVU: 56.4 **2012 NF PE RVU:**
2007 Fac PE RVU: 2.43 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35474 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 78,966

2007 Work RVU: 7.35 **2012 Work RVU:**
2007 NF PE RVU: 80.7 **2012 NF PE RVU:**
2007 Fac PE RVU: 2.9 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35475 **Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel**

Global: 000 **Issue:** Repair of Arterial and Venous Blockage **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 41 **Specialty Developing Recommendation:** ACR, RPA, SIR **First Identified:** September 2011 **2010 Medicare Utilization Data:** 34,402

2007 Work RVU: 9.48 **2012 Work RVU:** 9.48
2007 NF PE RVU: 53.95 **2012 NF PE RVU:** 57.92
2007 Fac PE RVU: 3.48 **2012 Fac PE RVU:** 3.74

RUC Recommendation: 6.60 **CPT Action (if applicable):** Removed from CPT referral **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35476 **Transluminal balloon angioplasty, percutaneous; venous**

Global: 000 **Issue:** Repair of Arterial and Venous Blockage **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 41 **Specialty Developing Recommendation:** ACR, RPA, SIR **First Identified:** **2010 Medicare Utilization Data:** 262,150

2007 Work RVU: 6.03 **2012 Work RVU:** 6.03
2007 NF PE RVU: 42.45 **2012 NF PE RVU:** 45.31
2007 Fac PE RVU: 2.26 **2012 Fac PE RVU:** 2.49

RUC Recommendation: 5.10 **CPT Action (if applicable):** Removed from CPT referral **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

35490 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 84

2007 Work RVU: 11.06 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 5.11 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35491 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 26

2007 Work RVU: 7.60 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 3.46 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35492 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 918

2007 Work RVU: 6.64 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 3.3 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35493 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 25,710

2007 Work RVU: 8.09 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 3.89 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35494 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 464

2007 Work RVU: 10.42 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 4.64 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35495 **Deleted from CPT**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 11,542

2007 Work RVU: 9.48 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 4.45 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

36000 **Introduction of needle or intracatheter, vein**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, AUR, AAP, AAFP, ACRh **First Identified:** October 2009 **2010 Medicare Utilization Data:** 208,841

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.54 **2012 NF PE RVU:** 0.55
2007 Fac PE RVU: 0.05 **2012 Fac PE RVU:** 0.08

RUC Recommendation: CMS consider a bundled status for this code **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36010 **Introduction of catheter, superior or inferior vena cava**

Global: XXX **Issue:** Introduction of Catheter **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 46 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 74,985

2007 Work RVU: 2.43 **2012 Work RVU:** 2.43
2007 NF PE RVU: 17.17 **2012 NF PE RVU:** 13.35
2007 Fac PE RVU: 0.77 **2012 Fac PE RVU:** 0.87

RUC Recommendation: Review September 2013 **CPT Action (if applicable):** February 2011 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

36140 **Introduction of needle or intracatheter; extremity artery**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 19 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACRO **First Identified:** April 2011 **2010 Medicare Utilization Data:** 31,233

2007 Work RVU: 2.01 **2012 Work RVU:** 2.01
2007 NF PE RVU: 12.15 **2012 NF PE RVU:** 11.63
2007 Fac PE RVU: 0.65 **2012 Fac PE RVU:** 0.72

RUC Recommendation: Review September 2013 **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

36145 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 2.01 **2012 Work RVU:**
2007 NF PE RVU: 11.87 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.64 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36147 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**

Global: XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 09 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 280,065

2007 Work RVU: **2012 Work RVU:** 3.72
2007 NF PE RVU: **2012 NF PE RVU:** 21.55
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.33

RUC Recommendation: 3.72 **CPT Action (if applicable):** October 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36148 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 09 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 64,456

2007 Work RVU: **2012 Work RVU:** 1
2007 NF PE RVU: **2012 NF PE RVU:** 6.81
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.34

RUC Recommendation: 1.00 **CPT Action (if applicable):** October 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36215 **Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family**

Global: XXX **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 79,039

2007 Work RVU: 4.67 **2012 Work RVU:** 4.67
2007 NF PE RVU: 26.59 **2012 NF PE RVU:** 29.03
2007 Fac PE RVU: 1.65 **2012 Fac PE RVU:** 1.84

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36216 **Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family**

Global: XXX **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 61,980

2007 Work RVU: 5.27 **2012 Work RVU:** 5.27
2007 NF PE RVU: 28.57 **2012 NF PE RVU:** 32.16
2007 Fac PE RVU: 1.82 **2012 Fac PE RVU:** 2.12

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

36217 **Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

Global: XXX **Issue:** Catheter Placement **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 20 **Specialty Developing Recommendation:** SVS, AUR, ACR, ASNR, SIR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 30,078

2007 Work RVU: 6.29 **2012 Work RVU:** 6.29
2007 NF PE RVU: 52.65 **2012 NF PE RVU:** 56.09
2007 Fac PE RVU: 2.17 **2012 Fac PE RVU:** 2.55

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

36221 **Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 4.51 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36222 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 6.00 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36223 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 6.50 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36224 **Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 7.55 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36225 **Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 6.50 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36226 **Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 7.55 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36227 **Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.32 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36228 **Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)**

Global: **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 4.25 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36245 **Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: XXX **Issue:** Renal Angiography **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2011 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 136,677

2007 Work RVU: 4.67 **2012 Work RVU:** 4.67
2007 NF PE RVU: 31.17 **2012 NF PE RVU:** 27.65
2007 Fac PE RVU: 1.78 **2012 Fac PE RVU:** 1.87

RUC Recommendation: 4.67 and Review October 2012 **CPT Action (if applicable):** February 2010 and February 2011 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

36246 **Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** No

Most Recent RUC Meeting: February 2011 **Tab** 25 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 62,692

2007 Work RVU: 5.27 **2012 Work RVU:** 5.27
2007 NF PE RVU: 29.18 **2012 NF PE RVU:** 24.28
2007 Fac PE RVU: 1.84 **2012 Fac PE RVU:** 1.95

RUC Recommendation: 5.27 and Review October 2012 **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36247 **Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** No

Most Recent RUC Meeting: February 2011 **Tab** 25 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 119,644

2007 Work RVU: 6.29 **2012 Work RVU:** 6.29
2007 NF PE RVU: 48.22 **2012 NF PE RVU:** 44.07
2007 Fac PE RVU: 2.17 **2012 Fac PE RVU:** 2.30

RUC Recommendation: 7.00 and Review October 2012 **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

36248 **Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Catheter Placement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 31,623

2007 Work RVU: 1.01 **2012 Work RVU:** 1.01
2007 NF PE RVU: 3.81 **2012 NF PE RVU:** 3.53
2007 Fac PE RVU: 0.35 **2012 Fac PE RVU:** 0.37

RUC Recommendation: Remove from screen **CPT Action (if applicable):** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

36251 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.35
2007 NF PE RVU: **2012 NF PE RVU:** 36.85
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.95

RUC Recommendation: 5.45 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36252 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.99
2007 NF PE RVU: **2012 NF PE RVU:** 39.13
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.52

RUC Recommendation: 7.38 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36253 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 7.55
2007 NF PE RVU: **2012 NF PE RVU:** 57.13
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.59

RUC Recommendation: 7.55 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36254 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 8.15
2007 NF PE RVU: **2012 NF PE RVU:** 59.09
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.79

RUC Recommendation: 8.15 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36410 **Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)**

Global: XXX **Issue:** Venipunture **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 36 **Specialty Developing Recommendation:** ACP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 249,192

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.3 **2012 NF PE RVU:** 0.31
2007 Fac PE RVU: 0.05 **2012 Fac PE RVU:** 0.07

RUC Recommendation: 0.18 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36481 **Percutaneous portal vein catheterization by any method**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2010 Medicare Utilization Data:** 971

2007 Work RVU: 6.98 **2012 Work RVU:** 6.98
2007 NF PE RVU: NA **2012 NF PE RVU:** 42.95
2007 Fac PE RVU: 2.46 **2012 Fac PE RVU:** 2.80

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

36516 **Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,475

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 75.37 **2012 NF PE RVU:** 60.36
2007 Fac PE RVU: 0.46 **2012 Fac PE RVU:** 0.51

RUC Recommendation: Review October 2012. CPT Assistant article published. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

Status Report: CMS Requests and Relativity Assessment Issues

36820 **Arteriovenous anastomosis, open; by forearm vein transposition** **Global:** 090 **Issue:** Arteriovenous Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,993

2007 Work RVU: 14.39 **2012 Work RVU:** 14.47
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.11 **2012 Fac PE RVU:** 6.98

RUC Recommendation: 14.39 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

36821 **Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)** **Global:** 090 **Issue:** Open Arterioventous Anastomosis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 26 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 37,185

2007 Work RVU: 9.15 **2012 Work RVU:** 12.11
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.49 **2012 Fac PE RVU:** 6.37

RUC Recommendation: 12.11 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36825 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft** **Global:** 090 **Issue:** Open Arterioventous Anastomosis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 26 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,019

2007 Work RVU: 10.00 **2012 Work RVU:** 14.17
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.87 **2012 Fac PE RVU:** 6.68

RUC Recommendation: 15.13 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36834 **Deleted from CPT** **Global:** **Issue:** Aneurysm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AVA, ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: 11.11 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 4.68 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36870 **Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)**

Global: 090 **Issue:** Thrombectomy **Screen:** Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2010 Medicare Utilization Data:** 60,952

2007 Work RVU: 5.17 **2012 Work RVU:** 5.2
2007 NF PE RVU: 49.54 **2012 NF PE RVU:** 51.16
2007 Fac PE RVU: 2.99 **2012 Fac PE RVU:** 3.19

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting. Reduced 99238 to 0.5

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

37183 **Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2010 Medicare Utilization Data:** 610

2007 Work RVU: 7.99 **2012 Work RVU:** 7.99
2007 NF PE RVU: NA **2012 NF PE RVU:** 160.15
2007 Fac PE RVU: 2.89 **2012 Fac PE RVU:** 3.13

RUC Recommendation: New PE inputs

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

37191 **Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4.71
2007 NF PE RVU: **2012 NF PE RVU:** 73.13
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.68

RUC Recommendation: 4.71

CPT Action (if applicable): February 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37192 **Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 7.35
2007 NF PE RVU: **2012 NF PE RVU:** 44.24
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.53

RUC Recommendation: 8.00 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37193 **Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 7.35
2007 NF PE RVU: **2012 NF PE RVU:** 41.84
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.52

RUC Recommendation: 8.00 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37201 **Transcatheter therapy, infusion for thrombolysis other than coronary**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 13,436

2007 Work RVU: 4.99 **2012 Work RVU:** 4.99
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.43 **2012 Fac PE RVU:** 2.53

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37203 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)**

Global: 000 **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 4,316

2007 Work RVU: 5.02 **2012 Work RVU:** 5.02
2007 NF PE RVU: 31.87 **2012 NF PE RVU:** 34.04
2007 Fac PE RVU: 1.98 **2012 Fac PE RVU:** 2.12

RUC Recommendation: Maintain. Editorially revised.

CPT Action (if applicable): June 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

37204 **Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck**

Global: 000 **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 28,334

2007 Work RVU: 18.11 **2012 Work RVU:** 18.11
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.75 **2012 Fac PE RVU:** 6.54

RUC Recommendation: Refer to CPT

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

37205 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth / Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 116,843

2007 Work RVU: 8.27 **2012 Work RVU:** 8.27
2007 NF PE RVU: NA **2012 NF PE RVU:** 117.83
2007 Fac PE RVU: 3.77 **2012 Fac PE RVU:** 3.15

RUC Recommendation: Refer to CPT

CPT Action (if applicable): February 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37206 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 29,503

2007 Work RVU: 4.12 **2012 Work RVU:** 4.12
2007 NF PE RVU: NA **2012 NF PE RVU:** 71.39
2007 Fac PE RVU: 1.46 **2012 Fac PE RVU:** 1.49

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

37207 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 4,829

2007 Work RVU: 8.27 **2012 Work RVU:** 8.27
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.98 **2012 Fac PE RVU:** 2.98

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

37208 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,350

2007 Work RVU: 4.12 **2012 Work RVU:** 4.12
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.3 **2012 Fac PE RVU:** 1.28

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37209 **Exchange of a previously placed intravascular catheter during thrombolytic therapy**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37211 **Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 8.00 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37212 **Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 7.06 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37213 **Transcatheter therapy, arterial other than coronary or venous infusion for thrombolysis, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 5.00 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37214 **Transcatheter therapy, arterial other than coronary or venous infusion for thrombolysis, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 3.04 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37220 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 8.15
2007 NF PE RVU: **2012 NF PE RVU:** 87.12
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.75

RUC Recommendation: 8.15 **CPT Action (if applicable):** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37221 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 10
2007 NF PE RVU: **2012 NF PE RVU:** 132.89
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.42

RUC Recommendation: 10.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37222 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.73
2007 NF PE RVU: **2012 NF PE RVU:** 23.32
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.21

RUC Recommendation: 3.73 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37223 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4.25
2007 NF PE RVU: **2012 NF PE RVU:** 74.25
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.38

RUC Recommendation: 4.25 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 9
2007 NF PE RVU: **2012 NF PE RVU:** 105.79
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.03

RUC Recommendation: 9.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 12
2007 NF PE RVU: **2012 NF PE RVU:** 316.59
2007 Fac PE RVU: **2012 Fac PE RVU:** 4.18

RUC Recommendation: 12.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37226 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 10.49
2007 NF PE RVU: **2012 NF PE RVU:** 267.55
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.59

RUC Recommendation: 10.49 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37227 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 14.5
2007 NF PE RVU: **2012 NF PE RVU:** 430.29
2007 Fac PE RVU: **2012 Fac PE RVU:** 5.03

RUC Recommendation: 14.50 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37228 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 11
2007 NF PE RVU: **2012 NF PE RVU:** 153.37
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.67

RUC Recommendation: 11.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37229 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 14.05
2007 NF PE RVU: **2012 NF PE RVU:** 310.42
2007 Fac PE RVU: **2012 Fac PE RVU:** 4.85

RUC Recommendation: 14.05 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37230 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 13.8
2007 NF PE RVU: **2012 NF PE RVU:** 243.00
2007 Fac PE RVU: **2012 Fac PE RVU:** 4.69

RUC Recommendation: 13.80 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37231 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 15
2007 NF PE RVU: **2012 NF PE RVU:** 399.23
2007 Fac PE RVU: **2012 Fac PE RVU:** 5.09

RUC Recommendation: 15.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37232 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4
2007 NF PE RVU: **2012 NF PE RVU:** 32.44
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.30

RUC Recommendation: 4.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37233 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.5
2007 NF PE RVU: **2012 NF PE RVU:** 37.36
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.20

RUC Recommendation: 6.50 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37234 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.5
2007 NF PE RVU: **2012 NF PE RVU:** 112.75
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.79

RUC Recommendation: 5.50 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37235 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 7.8
2007 NF PE RVU: **2012 NF PE RVU:** 117.95
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.54

RUC Recommendation: 7.80 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 19,766

2007 Work RVU: 3.02 **2012 Work RVU:** 3.05
2007 NF PE RVU: 4.43 **2012 NF PE RVU:** 5.65
2007 Fac PE RVU: 1.93 **2012 Fac PE RVU:** 2.56

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

37619 **Ligation of inferior vena cava**

Global: 090 **Issue:** Ligation of Inferior Vena Cava **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 13 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 30
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 11.90

RUC Recommendation: 37.60 **CPT Action (if applicable):** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

37620 **Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)**

Global: 090 **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 64,594

2007 Work RVU: 11.49 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 5.52 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37760 **Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg**

Global: 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,221

2007 Work RVU: 10.69 **2012 Work RVU:** 10.78
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.14 **2012 Fac PE RVU:** 6.11

RUC Recommendation: 10.69 **CPT Action (if applicable):** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37761 **Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg** **Global:** 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** **2010 Medicare Utilization Data:** 508

2007 Work RVU: **2012 Work RVU:** 9.13
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 5.79

RUC Recommendation: 9.00 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

37765 **Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions** **Global:** 090 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** 21 **Specialty Developing Recommendation:** ACS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 13,974

2007 Work RVU: 7.63 **2012 Work RVU:** 7.71
2007 NF PE RVU: NA **2012 NF PE RVU:** 10.86
2007 Fac PE RVU: 4.36 **2012 Fac PE RVU:** 4.60

RUC Recommendation: Review September 2013. Non-Facility PE Inputs. **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

37766 **Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions** **Global:** 090 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** 21 **Specialty Developing Recommendation:** ACS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 9,141

2007 Work RVU: 9.58 **2012 Work RVU:** 9.66
2007 NF PE RVU: NA **2012 NF PE RVU:** 12.15
2007 Fac PE RVU: 5.01 **2012 Fac PE RVU:** 5.28

RUC Recommendation: Review September 2013. Non-Facility PE Inputs. **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

37785 **Ligation, division, and/or excision of varicose vein cluster(s), 1 leg** **Global:** 090 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,608

2007 Work RVU: 3.87 **2012 Work RVU:** 3.93
2007 NF PE RVU: 5.12 **2012 NF PE RVU:** 6.08
2007 Fac PE RVU: 2.69 **2012 Fac PE RVU:** 3.23

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38542 **Dissection, deep jugular node(s)** **Global:** 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 924

2007 Work RVU: 6.08 **2012 Work RVU:** 7.95
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.3 **2012 Fac PE RVU:** 6.09

RUC Recommendation: 7.85 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38571 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy** **Global:** 010 **Issue:** Laparoscopic Pelvic Lymphadenectomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 7,078

2007 Work RVU: 14.70 **2012 Work RVU:** 14.76
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.97 **2012 Fac PE RVU:** 7.15

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

40490 **Biopsy of lip** **Global:** 000 **Issue:** Biopsy of Lip **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 21 **Specialty Developing Recommendation:** AAO-HNS, AAD **First Identified:** April 2011 **2010 Medicare Utilization Data:** 37,498

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 1.75 **2012 NF PE RVU:** 2.42
2007 Fac PE RVU: 0.61 **2012 Fac PE RVU:** 0.80

RUC Recommendation: 1.22 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42145 **Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)** **Global:** 090 **Issue:** Palatopharyngoplasty **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 41 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,654

2007 Work RVU: 9.63 **2012 Work RVU:** 9.78
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.33 **2012 Fac PE RVU:** 10.24

RUC Recommendation: 9.63 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

42415 **Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,592

2007 Work RVU: 17.99 **2012 Work RVU:** 17.16
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.11 **2012 Fac PE RVU:** 12.43

RUC Recommendation: 18.12 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42420 **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,567

2007 Work RVU: 20.87 **2012 Work RVU:** 19.53
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.46 **2012 Fac PE RVU:** 13.71

RUC Recommendation: 21.00 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42440 **Excision of submandibular (submaxillary) gland**

Global: 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 64 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,098

2007 Work RVU: 7.05 **2012 Work RVU:** 6.14
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.48 **2012 Fac PE RVU:** 5.56

RUC Recommendation: 7.13 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43200 **Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 15,082

2007 Work RVU: 1.59 **2012 Work RVU:** 1.59
2007 NF PE RVU: 3.98 **2012 NF PE RVU:** 4.71
2007 Fac PE RVU: 1.04 **2012 Fac PE RVU:** 1.32

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. **CPT Action (if applicable):** May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43201 **Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 441

2007 Work RVU: 2.09 **2012 Work RVU:** 2.09
2007 NF PE RVU: 4.86 **2012 NF PE RVU:** 6.88
2007 Fac PE RVU: 1.12 **2012 Fac PE RVU:** 1.45

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43202 **Esophagoscopy, rigid or flexible; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 4,123

2007 Work RVU: 1.89 **2012 Work RVU:** 1.89
2007 NF PE RVU: 5.44 **2012 NF PE RVU:** 6.42
2007 Fac PE RVU: 0.95 **2012 Fac PE RVU:** 1.28

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43204 **Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 110

2007 Work RVU: 3.76 **2012 Work RVU:** 3.76
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.63 **2012 Fac PE RVU:** 2.22

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43205 **Esophagoscopy, rigid or flexible; with band ligation of esophageal varices** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 247

2007 Work RVU: 3.78 **2012 Work RVU:** 3.78
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.66 **2012 Fac PE RVU:** 2.37

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43206 **Esophagoscopy, rigid or flexible; with optical endomicroscopy** **Global:** **Issue:** Optical Endomicroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, CAP **First Identified:** September 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price

CPT Action (if applicable): **Result:** Carrier Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

43215 **Esophagoscopy, rigid or flexible; with removal of foreign body** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,671

2007 Work RVU: 2.60 **2012 Work RVU:** 2.6
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.22 **2012 Fac PE RVU:** 1.62

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43216 **Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 106

2007 Work RVU: 2.40 **2012 Work RVU:** 2.4
2007 NF PE RVU: 1.55 **2012 NF PE RVU:** 3.65
2007 Fac PE RVU: 1.1 **2012 Fac PE RVU:** 1.57

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43217 **Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 273

2007 Work RVU: 2.90 **2012 Work RVU:** 2.9
2007 NF PE RVU: 6.85 **2012 NF PE RVU:** 8.08
2007 Fac PE RVU: 1.25 **2012 Fac PE RVU:** 1.72

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43219 **Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 716

2007 Work RVU: 2.80 **2012 Work RVU:** 2.8
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.4 **2012 Fac PE RVU:** 1.85

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43220 **Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,954

2007 Work RVU: 2.10 **2012 Work RVU:** 2.1
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.01 **2012 Fac PE RVU:** 1.39

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43226 **Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,554

2007 Work RVU: 2.34 **2012 Work RVU:** 2.34
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.1 **2012 Fac PE RVU:** 1.52

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43227 **Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 664

2007 Work RVU: 3.59 **2012 Work RVU:** 3.59
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.55 **2012 Fac PE RVU:** 2.18

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43228 **Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 4,153

2007 Work RVU: 3.76 **2012 Work RVU:** 3.76
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.63 **2012 Fac PE RVU:** 2.32

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43231 **Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 423

2007 Work RVU: 3.19 **2012 Work RVU:** 3.19
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.42 **2012 Fac PE RVU:** 2.03

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43232 **Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 366

2007 Work RVU: 4.47 **2012 Work RVU:** 4.47
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.96 **2012 Fac PE RVU:** 2.63

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43234 **Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)** **Global:** 000 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,005

2007 Work RVU: 2.01 **2012 Work RVU:** 2.01
2007 NF PE RVU: 5.23 **2012 NF PE RVU:** 6.16
2007 Fac PE RVU: 0.91 **2012 Fac PE RVU:** 1.27

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43235 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** **Screen:** MPC List / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: October 2010 **2010 Medicare Utilization Data:** 399,111

2007 Work RVU: 2.39 **2012 Work RVU:** 2.39
2007 NF PE RVU: 5.19 **2012 NF PE RVU:** 6.19
2007 Fac PE RVU: 1.11 **2012 Fac PE RVU:** 1.59

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43236 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Gastrointestinal Endoscopy **Screen:** CMS Fastest Growing / MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AGA, ASGE, SAGES

First Identified: October 2008 **2010 Medicare Utilization Data:** 13,502

2007 Work RVU: 2.92 **2012 Work RVU:** 2.92
2007 NF PE RVU: 6.47 **2012 NF PE RVU:** 8.04
2007 Fac PE RVU: 1.33 **2012 Fac PE RVU:** 1.90

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. CPT Assistant article published.

CPT Action (if applicable): February 2012 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2009 and Jun 2

43237 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 827

2007 Work RVU: 3.98 **2012 Work RVU:** 3.98
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.74 **2012 Fac PE RVU:** 2.42

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43238 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 676

2007 Work RVU: 5.02 **2012 Work RVU:** 5.02
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.11 **2012 Fac PE RVU:** 2.97

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43239 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple**

Global: 000 **Issue:** Upper GI Endoscopy Biopsy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 42 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,440,278

2007 Work RVU: 2.87 **2012 Work RVU:** 2.87
2007 NF PE RVU: 5.79 **2012 NF PE RVU:** 7.04
2007 Fac PE RVU: 1.29 **2012 Fac PE RVU:** 1.84

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. Remove from MPC List

CPT Action (if applicable): February 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43240 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 265

2007 Work RVU: 6.85 **2012 Work RVU:** 6.85
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.82 **2012 Fac PE RVU:** 3.96

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43241 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,889

2007 Work RVU: 2.59 **2012 Work RVU:** 2.59
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.18 **2012 Fac PE RVU:** 1.68

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43242 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)**

Global: 000 **Issue:** Gastrointestinal Endoscopy **Screen:** CMS Fastest Growing / MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AGA, ASGE, SAGES

First Identified: October 2008 **2010 Medicare Utilization Data:** 22,973

2007 Work RVU: 7.30 **2012 Work RVU:** 7.3
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.98 **2012 Fac PE RVU:** 4.25

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. CPT Assistant article published.

CPT Action (if applicable): February 2012 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43243 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,504

2007 Work RVU: 4.56 **2012 Work RVU:** 4.56
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.94 **2012 Fac PE RVU:** 2.74

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43244 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 14,560

2007 Work RVU: 5.04 **2012 Work RVU:** 5.04
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.14 **2012 Fac PE RVU:** 3.04

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43245 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 12,873

2007 Work RVU: 3.18 **2012 Work RVU:** 3.18
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.39 **2012 Fac PE RVU:** 1.94

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43246 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 122,884

2007 Work RVU: 4.32 **2012 Work RVU:** 4.32
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.8 **2012 Fac PE RVU:** 2.51

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43247 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 27,419

2007 Work RVU: 3.38 **2012 Work RVU:** 3.38
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.48 **2012 Fac PE RVU:** 2.09

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43248 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 99,050

2007 Work RVU: 3.15 **2012 Work RVU:** 3.15
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.43 **2012 Fac PE RVU:** 2.03

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43249 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 86,888

2007 Work RVU: 2.90 **2012 Work RVU:** 2.9
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.32 **2012 Fac PE RVU:** 1.87

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43250 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 6,942

2007 Work RVU: 3.20 **2012 Work RVU:** 3.2
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.4 **2012 Fac PE RVU:** 1.93

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43251 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 26,727

2007 Work RVU: 3.69 **2012 Work RVU:** 3.69
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.6 **2012 Fac PE RVU:** 2.27

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43252 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy**

Global: **Issue:** Optical Endomicroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, CAP **First Identified:** September 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price

CPT Action (if applicable): **Result:** Carrier Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43255 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 52,824

2007 Work RVU: 4.81 **2012 Work RVU:** 4.81
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.05 **2012 Fac PE RVU:** 2.91

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43256 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 3,536

2007 Work RVU: 4.34 **2012 Work RVU:** 4.34
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.85 **2012 Fac PE RVU:** 2.57

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43257 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 43

2007 Work RVU: 5.50 **2012 Work RVU:** 5.5
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.16 **2012 Fac PE RVU:** 3.28

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43258 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 15,303

2007 Work RVU: 4.54 **2012 Work RVU:** 4.54
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.94 **2012 Fac PE RVU:** 2.75

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43259 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate**

Global: 000 **Issue:** Gastrointestinal Endoscopy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AGA, ASGE, SAGES

First Identified: October 2008 **2010 Medicare Utilization Data:** 32,330

2007 Work RVU: 5.19 **2012 Work RVU:** 5.19
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.17 **2012 Fac PE RVU:** 3.12

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2012 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43260 **Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 12,299

2007 Work RVU: 5.95 **2012 Work RVU:** 5.95
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.49 **2012 Fac PE RVU:** 3.52

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43261 **Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting:
Tab
Specialty Developing Recommendation:
First Identified: September 2011
2010 Medicare Utilization Data: 1,567

2007 Work RVU: 6.26 **2012 Work RVU:** 6.26
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.61 **2012 Fac PE RVU:** 3.69

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013
Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

43262 **Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting:
Tab
Specialty Developing Recommendation:
First Identified: September 2011
2010 Medicare Utilization Data: 57,558

2007 Work RVU: 7.38 **2012 Work RVU:** 7.38
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.03 **2012 Fac PE RVU:** 4.29

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013
Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

43263 **Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting:
Tab
Specialty Developing Recommendation:
First Identified: September 2011
2010 Medicare Utilization Data: 804

2007 Work RVU: 7.28 **2012 Work RVU:** 7.28
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.02 **2012 Fac PE RVU:** 4.24

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013
Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43264 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts**

Global: 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2010 Medicare Utilization Data:** 44,428

2007 Work RVU: 8.89 **2012 Work RVU:** 8.89
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.61 **2012 Fac PE RVU:** 5.11

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43265 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,730

2007 Work RVU: 10.00 **2012 Work RVU:** 10
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.03 **2012 Fac PE RVU:** 5.69

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43267 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 311

2007 Work RVU: 7.38 **2012 Work RVU:** 7.38
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.01 **2012 Fac PE RVU:** 4.24

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43268 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct**

Global: 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2010 Medicare Utilization Data:** 35,681

2007 Work RVU: 7.38 **2012 Work RVU:** 7.38
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.15 **2012 Fac PE RVU:** 4.47

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43269 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 19,975

2007 Work RVU: 8.20 **2012 Work RVU:** 8.2
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.35 **2012 Fac PE RVU:** 4.73

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43271 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 11,625

2007 Work RVU: 7.38 **2012 Work RVU:** 7.38
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.03 **2012 Fac PE RVU:** 4.28

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43272 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 376

2007 Work RVU: 7.38 **2012 Work RVU:** 7.38
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.05 **2012 Fac PE RVU:** 4.29

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43273 **Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)**

Global: ZZZ **Issue:** ERCP **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 3,548

2007 Work RVU: **2012 Work RVU:** 2.24
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.22

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43453 **Dilation of esophagus, over guide wire**

Global: **Issue:** Dilation **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 3,573

2007 Work RVU: 1.51 **2012 Work RVU:** 1.51
2007 NF PE RVU: 6.12 **2012 NF PE RVU:** 7.15
2007 Fac PE RVU: 0.8 **2012 Fac PE RVU:** 1.14

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43456 **Dilation of esophagus, by balloon or dilator, retrograde** **Global:** **Issue:** Dilation **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,776

2007 Work RVU: 2.57 **2012 Work RVU:** 2.57
2007 NF PE RVU: 13.55 **2012 NF PE RVU:** 15.10
2007 Fac PE RVU: 1.2 **2012 Fac PE RVU:** 1.68

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

43458 **Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia** **Global:** **Issue:** Dilation **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,446

2007 Work RVU: 3.06 **2012 Work RVU:** 3.06
2007 NF PE RVU: 6.72 **2012 NF PE RVU:** 8.13
2007 Fac PE RVU: 1.37 **2012 Fac PE RVU:** 1.90

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44205 **Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 9,431

2007 Work RVU: 22.86 **2012 Work RVU:** 22.95
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 8.6 **2012 Fac PE RVU:** 11.75

RUC Recommendation: Remove from screen

CPT Action (if applicable): **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

44207 **Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 6,071

2007 Work RVU: 31.79 **2012 Work RVU:** 31.92
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.17 **2012 Fac PE RVU:** 15.43

RUC Recommendation: Remove from screen

CPT Action (if applicable): **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44360 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 5,761

2007 Work RVU: 2.59 **2012 Work RVU:** 2.59
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.21 **2012 Fac PE RVU:** 1.73

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44361 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 15,229

2007 Work RVU: 2.87 **2012 Work RVU:** 2.87
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.32 **2012 Fac PE RVU:** 1.89

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44363 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 140

2007 Work RVU: 3.49 **2012 Work RVU:** 3.49
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.53 **2012 Fac PE RVU:** 2.17

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44364 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 290

2007 Work RVU: 3.73 **2012 Work RVU:** 3.73
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.63 **2012 Fac PE RVU:** 2.33

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44365 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 203

2007 Work RVU: 3.31 **2012 Work RVU:** 3.31
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.47 **2012 Fac PE RVU:** 2.11

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44366 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,865

2007 Work RVU: 4.40 **2012 Work RVU:** 4.4
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.9 **2012 Fac PE RVU:** 2.71

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44369 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,261

2007 Work RVU: 4.51 **2012 Work RVU:** 4.51
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.91 **2012 Fac PE RVU:** 2.77

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44370 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 112

2007 Work RVU: 4.79 **2012 Work RVU:** 4.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.12 **2012 Fac PE RVU:** 3.07

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44372 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,361

2007 Work RVU: 4.40 **2012 Work RVU:** 4.4
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.84 **2012 Fac PE RVU:** 2.55

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44373 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube**

Global: 000 **Issue:** Enteroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,541

2007 Work RVU: 3.49 **2012 Work RVU:** 3.49
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.5 **2012 Fac PE RVU:** 2.13

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44376 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Enteroscopy to Ileum **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,012

2007 Work RVU: 5.25 **2012 Work RVU:** 5.25
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.14 **2012 Fac PE RVU:** 3.00

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44377 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple**

Global: 000 **Issue:** Enteroscopy to Ileum **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,620

2007 Work RVU: 5.52 **2012 Work RVU:** 5.52
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.31 **2012 Fac PE RVU:** 3.25

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44378 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

Global: 000 **Issue:** Enteroscopy to Ileum **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 933

2007 Work RVU: 7.12 **2012 Work RVU:** 7.12
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.92 **2012 Fac PE RVU:** 4.13

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44379 **Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** Enteroscopy to Ileum **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 20

2007 Work RVU: 7.46 **2012 Work RVU:** 7.46
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.02 **2012 Fac PE RVU:** 4.53

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): January 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44380 **Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,048

2007 Work RVU: 1.05 **2012 Work RVU:** 1.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.6 **2012 Fac PE RVU:** 0.85

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44382 **Ileoscopy, through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Ileoscopy Ileoscopy Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,343

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.67 **2012 Fac PE RVU:** 0.99

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44383 **Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 270

2007 Work RVU: 2.94 **2012 Work RVU:** 2.94
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.36 **2012 Fac PE RVU:** 1.64

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44385 **Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 923

2007 Work RVU: 1.82 **2012 Work RVU:** 1.82
2007 NF PE RVU: 3.73 **2012 NF PE RVU:** 5.66
2007 Fac PE RVU: 0.79 **2012 Fac PE RVU:** 1.08

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44386 **Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 753

2007 Work RVU: 2.12 **2012 Work RVU:** 2.12
2007 NF PE RVU: 6.66 **2012 NF PE RVU:** 8.16
2007 Fac PE RVU: 0.93 **2012 Fac PE RVU:** 1.33

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44388 **Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 5,073

2007 Work RVU: 2.82 **2012 Work RVU:** 2.82
2007 NF PE RVU: 5.34 **2012 NF PE RVU:** 7.33
2007 Fac PE RVU: 1.21 **2012 Fac PE RVU:** 1.69

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44389 **Colonoscopy through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,944

2007 Work RVU: 3.13 **2012 Work RVU:** 3.13
2007 NF PE RVU: 6.73 **2012 NF PE RVU:** 8.43
2007 Fac PE RVU: 1.35 **2012 Fac PE RVU:** 1.91

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44390 **Colonoscopy through stoma; with removal of foreign body** **Global:** 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 47

2007 Work RVU: 3.82 **2012 Work RVU:** 3.82
2007 NF PE RVU: 7.32 **2012 NF PE RVU:** 9.17
2007 Fac PE RVU: 1.57 **2012 Fac PE RVU:** 2.13

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44391 **Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)** **Global:** 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 190

2007 Work RVU: 4.31 **2012 Work RVU:** 4.31
2007 NF PE RVU: 8.78 **2012 NF PE RVU:** 10.25
2007 Fac PE RVU: 1.83 **2012 Fac PE RVU:** 2.53

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44392 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery** **Global:** 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 739

2007 Work RVU: 3.81 **2012 Work RVU:** 3.81
2007 NF PE RVU: 6.78 **2012 NF PE RVU:** 8.85
2007 Fac PE RVU: 1.55 **2012 Fac PE RVU:** 2.11

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44393 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 241

2007 Work RVU: 4.83 **2012 Work RVU:** 4.83
2007 NF PE RVU: 7.14 **2012 NF PE RVU:** 9.67
2007 Fac PE RVU: 1.91 **2012 Fac PE RVU:** 2.70

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44394 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,182

2007 Work RVU: 4.42 **2012 Work RVU:** 4.42
2007 NF PE RVU: 7.97 **2012 NF PE RVU:** 10.00
2007 Fac PE RVU: 1.81 **2012 Fac PE RVU:** 2.53

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

44397 **Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 14

2007 Work RVU: 4.70 **2012 Work RVU:** 4.7
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.93 **2012 Fac PE RVU:** 2.84

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44970 **Laparoscopy, surgical, appendectomy** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 16,807

2007 Work RVU: 9.35 **2012 Work RVU:** 9.45
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.11 **2012 Fac PE RVU:** 6.06

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

45170 **Deleted from CPT** **Global:** **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: 12.48 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 5.28 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45171 **Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)** **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,422

2007 Work RVU: **2012 Work RVU:** 8.13
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 8.21

RUC Recommendation: 8.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45172 **Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)** **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,066

2007 Work RVU: **2012 Work RVU:** 12.13
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 9.77

RUC Recommendation: 12.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45330 **Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Diagnostic Sigmoidoscopy **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 22 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2010 Medicare Utilization Data:** 69,122

2007 Work RVU: 0.96 **2012 Work RVU:** 0.96
2007 NF PE RVU: 2.33 **2012 NF PE RVU:** 3.10
2007 Fac PE RVU: 0.53 **2012 Fac PE RVU:** 0.79

RUC Recommendation: Specialty intends on revising entire GI endoscopy family. 0.96

CPT Action (if applicable): May 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

45331 **Sigmoidoscopy, flexible; with biopsy, single or multiple**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 37,285

2007 Work RVU: 1.15 **2012 Work RVU:** 1.15
2007 NF PE RVU: 3.11 **2012 NF PE RVU:** 3.70
2007 Fac PE RVU: 0.64 **2012 Fac PE RVU:** 0.94

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45332 **Sigmoidoscopy, flexible; with removal of foreign body**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 271

2007 Work RVU: 1.79 **2012 Work RVU:** 1.79
2007 NF PE RVU: 5.15 **2012 NF PE RVU:** 6.73
2007 Fac PE RVU: 0.86 **2012 Fac PE RVU:** 1.24

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45333 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,104

2007 Work RVU: 1.79 **2012 Work RVU:** 1.79
2007 NF PE RVU: 5.06 **2012 NF PE RVU:** 6.85
2007 Fac PE RVU: 0.85 **2012 Fac PE RVU:** 1.21

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45334 **Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 3,323

2007 Work RVU: 2.73 **2012 Work RVU:** 2.73
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.24 **2012 Fac PE RVU:** 1.77

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45335 **Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,450

2007 Work RVU: 1.46 **2012 Work RVU:** 1.46
2007 NF PE RVU: 3.74 **2012 NF PE RVU:** 6.45
2007 Fac PE RVU: 0.75 **2012 Fac PE RVU:** 1.07

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45337 **Sigmoidoscopy, flexible; with decompression of volvulus, any method** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 943

2007 Work RVU: 2.36 **2012 Work RVU:** 2.36
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.06 **2012 Fac PE RVU:** 1.50

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45338 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 4,583

2007 Work RVU: 2.34 **2012 Work RVU:** 2.34
2007 NF PE RVU: 5.37 **2012 NF PE RVU:** 6.96
2007 Fac PE RVU: 1.07 **2012 Fac PE RVU:** 1.53

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45339 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,665

2007 Work RVU: 3.14 **2012 Work RVU:** 3.14
2007 NF PE RVU: 4.03 **2012 NF PE RVU:** 6.60
2007 Fac PE RVU: 1.38 **2012 Fac PE RVU:** 1.94

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45340 **Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,038

2007 Work RVU: 1.89 **2012 Work RVU:** 1.89
2007 NF PE RVU: 7.18 **2012 NF PE RVU:** 12.30
2007 Fac PE RVU: 0.89 **2012 Fac PE RVU:** 1.28

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45341 **Sigmoidoscopy, flexible; with endoscopic ultrasound examination** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 3,354

2007 Work RVU: 2.60 **2012 Work RVU:** 2.6
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.17 **2012 Fac PE RVU:** 1.70

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45342 **Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 326

2007 Work RVU: 4.05 **2012 Work RVU:** 4.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.71 **2012 Fac PE RVU:** 2.50

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45345 **Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 467

2007 Work RVU: 2.92 **2012 Work RVU:** 2.92
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.26 **2012 Fac PE RVU:** 1.83

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): May 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45355 **Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple**

Global: 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 750

2007 Work RVU: 3.51 **2012 Work RVU:** 3.51
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.43 **2012 Fac PE RVU:** 1.99

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45378 **Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)**

Global: 000 **Issue:** Flexible Colonoscopy **Screen:** CMS High Expenditure Procedural Codes / MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 758,466

2007 Work RVU: 3.69 **2012 Work RVU:** 3.69
2007 NF PE RVU: 6.2 **2012 NF PE RVU:** 7.55
2007 Fac PE RVU: 1.57 **2012 Fac PE RVU:** 2.20

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45379 **Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body** **Global:** 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 852

2007 Work RVU: 4.68 **2012 Work RVU:** 4.68
2007 NF PE RVU: 7.78 **2012 NF PE RVU:** 9.72
2007 Fac PE RVU: 1.92 **2012 Fac PE RVU:** 2.70

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45380 **Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 34 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2010 Medicare Utilization Data:** 829,160

2007 Work RVU: 4.43 **2012 Work RVU:** 4.43
2007 NF PE RVU: 7.33 **2012 NF PE RVU:** 9.02
2007 Fac PE RVU: 1.87 **2012 Fac PE RVU:** 2.65

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. Remove from MPC List.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45381 **Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS Fastest Growing / MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2008 **2010 Medicare Utilization Data:** 54,862

2007 Work RVU: 4.19 **2012 Work RVU:** 4.19
2007 NF PE RVU: 7.26 **2012 NF PE RVU:** 9.26
2007 Fac PE RVU: 1.79 **2012 Fac PE RVU:** 2.53

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. Review September 2013 if not addressed in entire review. CPT Assistant article published.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

Status Report: CMS Requests and Relativity Assessment Issues

45382 **Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 21,136

2007 Work RVU: 5.68 **2012 Work RVU:** 5.68
2007 NF PE RVU: 10.04 **2012 NF PE RVU:** 11.92
2007 Fac PE RVU: 2.37 **2012 Fac PE RVU:** 3.35

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45383 **Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 56,440

2007 Work RVU: 5.86 **2012 Work RVU:** 5.86
2007 NF PE RVU: 8.08 **2012 NF PE RVU:** 10.24
2007 Fac PE RVU: 2.34 **2012 Fac PE RVU:** 3.25

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45384 **Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 179,190

2007 Work RVU: 4.69 **2012 Work RVU:** 4.69
2007 NF PE RVU: 6.9 **2012 NF PE RVU:** 8.59
2007 Fac PE RVU: 1.93 **2012 Fac PE RVU:** 2.66

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45385 **Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 34 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2010 Medicare Utilization Data:** 640,634

2007 Work RVU: 5.30 **2012 Work RVU:** 5.3
2007 NF PE RVU: 7.94 **2012 NF PE RVU:** 9.79
2007 Fac PE RVU: 2.18 **2012 Fac PE RVU:** 3.09

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. Remove from MPC List.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45386 **Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,152

2007 Work RVU: 4.57 **2012 Work RVU:** 4.57
2007 NF PE RVU: 12.37 **2012 NF PE RVU:** 14.94
2007 Fac PE RVU: 1.89 **2012 Fac PE RVU:** 2.65

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45387 **Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 655

2007 Work RVU: 5.90 **2012 Work RVU:** 5.9
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.49 **2012 Fac PE RVU:** 3.52

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45391 **Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 577

2007 Work RVU: 5.09 **2012 Work RVU:** 5.09
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.13 **2012 Fac PE RVU:** 2.99

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

45392 **Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 137

2007 Work RVU: 6.54 **2012 Work RVU:** 6.54
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.65 **2012 Fac PE RVU:** 3.78

RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.

CPT Action (if applicable): October 2013 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

46200 **Fissurectomy, including sphincterotomy, when performed**

Global: 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS

First Identified: September 2007 **2010 Medicare Utilization Data:** 1,640

2007 Work RVU: 3.48 **2012 Work RVU:** 3.59
2007 NF PE RVU: 4.46 **2012 NF PE RVU:** 8.47
2007 Fac PE RVU: 3.08 **2012 Fac PE RVU:** 5.17

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable): **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47382 **Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency**

Global: 010 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2010 Medicare Utilization Data:** 1,601

2007 Work RVU: 15.19 **2012 Work RVU:** 15.22
2007 NF PE RVU: NA **2012 NF PE RVU:** 127.66
2007 Fac PE RVU: 5.83 **2012 Fac PE RVU:** 6.40

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

47490 **Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation**

Global: 010 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 04 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 7,223

2007 Work RVU: 8.05 **2012 Work RVU:** 4.76
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.32 **2012 Fac PE RVU:** 4.97

RUC Recommendation: 4.76 **CPT Action (if applicable):** June 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

47525 **Change of percutaneous biliary drainage catheter**

Global: 000 **Issue:** Change Biliary Drainage Catheter **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 14 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 10,725

2007 Work RVU: 5.55 **2012 Work RVU:** 1.54
2007 NF PE RVU: 14.8 **2012 NF PE RVU:** 13.42
2007 Fac PE RVU: 2.67 **2012 Fac PE RVU:** 0.99

RUC Recommendation: 1.54 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

47562 **Laparoscopy, surgical; cholecystectomy**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 116,094

2007 Work RVU: 11.63 **2012 Work RVU:** 11.76
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.06 **2012 Fac PE RVU:** 7.61

RUC Recommendation: Reaffirmed **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47563 **Laparoscopy, surgical; cholecystectomy with cholangiography**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 59,873

2007 Work RVU: 12.03 **2012 Work RVU:** 11.47
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.24 **2012 Fac PE RVU:** 7.03

RUC Recommendation: 12.11 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

47600 **Cholecystectomy;**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2010 Medicare Utilization Data:** 17,084

2007 Work RVU: 17.35 **2012 Work RVU:** 17.48
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.4 **2012 Fac PE RVU:** 10.36

RUC Recommendation: 20.00 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47605 **Cholecystectomy; with cholangiography**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2010 Medicare Utilization Data:** 4,202

2007 Work RVU: 15.90 **2012 Work RVU:** 15.98
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.47 **2012 Fac PE RVU:** 9.26

RUC Recommendation: 21.00 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

48102 **Biopsy of pancreas, percutaneous needle**

Global: 010 **Issue:** Percutaneous Needle Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,518

2007 Work RVU: 4.68 **2012 Work RVU:** 4.7
2007 NF PE RVU: 8.21 **2012 NF PE RVU:** 10.84
2007 Fac PE RVU: 1.85 **2012 Fac PE RVU:** 2.03

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49080 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial**

Global: 000 **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 153,121

2007 Work RVU: 1.35 **2012 Work RVU:**
2007 NF PE RVU: 3.63 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.45 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** June 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49081 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent**

Global: 000 **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 5 **Specialty Developing Recommendation:** **First Identified:** February 2010 **2010 Medicare Utilization Data:** 7,564

2007 Work RVU: 1.26 **2012 Work RVU:**
2007 NF PE RVU: 2.65 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.43 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** June 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49082 **Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance**

Global: 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.24
2007 NF PE RVU: **2012 NF PE RVU:** 3.47
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.70

RUC Recommendation: 1.35 **CPT Action (if applicable):** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49083 **Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance**

Global: 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2
2007 NF PE RVU: **2012 NF PE RVU:** 6.91
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.98

RUC Recommendation: 2.00 **CPT Action (if applicable):** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49084 **Peritoneal lavage, including imaging guidance, when performed**

Global: 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.71

RUC Recommendation: 2.50 **CPT Action (if applicable):** June 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

49418 **Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4.21
2007 NF PE RVU: **2012 NF PE RVU:** 41.99
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.93

RUC Recommendation: 4.21 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49420 **Deleted from CPT**

Global: 000 **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 5,149

2007 Work RVU: 2.22 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 1.11 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49421 **Insertion of tunneled intraperitoneal catheter for dialysis, open** **Global:** 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** September 2007 **2010 Medicare Utilization Data:** 6,572

2007 Work RVU: 5.87 **2012 Work RVU:** 4.21
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.15 **2012 Fac PE RVU:** 2.30

RUC Recommendation: 4.21 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49505 **Repair initial inguinal hernia, age 5 years or older; reducible** **Global:** 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 80,558

2007 Work RVU: 7.88 **2012 Work RVU:** 7.96
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.78 **2012 Fac PE RVU:** 5.53

RUC Recommendation: Reaffirmed **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49507 **Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 12,065

2007 Work RVU: 9.97 **2012 Work RVU:** 9.09
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.46 **2012 Fac PE RVU:** 6.13

RUC Recommendation: 10.05 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49521 **Repair recurrent inguinal hernia, any age; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,611

2007 Work RVU: 12.36 **2012 Work RVU:** 11.48
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.18 **2012 Fac PE RVU:** 7.03

RUC Recommendation: 12.44 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 9,476

2007 Work RVU: 7.96 **2012 Work RVU:** 7.08
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.77 **2012 Fac PE RVU:** 5.33

RUC Recommendation: 8.04 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49652 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2010 Medicare Utilization Data:** 6,870

2007 Work RVU: **2012 Work RVU:** 11.92
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 7.34

RUC Recommendation: 12.88 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49653 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2010 Medicare Utilization Data:** 2,877

2007 Work RVU: **2012 Work RVU:** 14.94
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 9.08

RUC Recommendation: 16.21 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49654 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2010 Medicare Utilization Data:** 5,943

2007 Work RVU: **2012 Work RVU:** 13.76
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 8.09

RUC Recommendation: 15.03 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49655 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2010 Medicare Utilization Data:** 2,673

2007 Work RVU: **2012 Work RVU:** 16.84
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 9.83

RUC Recommendation: 18.11 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50200 **Renal biopsy; percutaneous, by trocar or needle**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2010 Medicare Utilization Data:** 29,504

2007 Work RVU: 2.63 **2012 Work RVU:** 2.63
2007 NF PE RVU: NA **2012 NF PE RVU:** 14.87
2007 Fac PE RVU: 1.24 **2012 Fac PE RVU:** 1.32

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

50542 **Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 784

2007 Work RVU: 21.18 **2012 Work RVU:** 21.36
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 8.93 **2012 Fac PE RVU:** 11.09

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

50548 **Laparoscopy, surgical; nephrectomy with total ureterectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,528

2007 Work RVU: 25.26 **2012 Work RVU:** 25.36
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.99 **2012 Fac PE RVU:** 12.05

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50590 **Lithotripsy, extracorporeal shock wave**

Global: 090 **Issue:** Lithotripsy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 42 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 54,419

2007 Work RVU: 9.64 **2012 Work RVU:** 9.77
2007 NF PE RVU: 13.6 **2012 NF PE RVU:** 13.42
2007 Fac PE RVU: 4.65 **2012 Fac PE RVU:** 6.02

RUC Recommendation: 9.77 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50605 **Ureterotomy for insertion of indwelling stent, all types**

Global: 090 **Issue:** Ureterotomy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AUA, SIR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 3,584

2007 Work RVU: 16.66 **2012 Work RVU:** 16.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.06 **2012 Fac PE RVU:** 9.29

RUC Recommendation: Review September 2014. CPT Assistant article published. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

51040 **Cystostomy, cystotomy with drainage**

Global: 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 6,142

2007 Work RVU: 4.43 **2012 Work RVU:** 4.49
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.01 **2012 Fac PE RVU:** 3.67

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

51102 **Aspiration of bladder; with insertion of suprapubic catheter**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 13,947

2007 Work RVU: **2012 Work RVU:** 2.7
2007 NF PE RVU: **2012 NF PE RVU:** 3.82
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.35

RUC Recommendation: 2.70 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51726 **Complex cystometrogram (ie, calibrated electronic equipment);** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2008 **2010 Medicare Utilization Data:** 25,230

2007 Work RVU: 1.71 **2012 Work RVU:** 1.71
2007 NF PE RVU: 7.41 **2012 NF PE RVU:** 6.73
2007 Fac PE RVU: 7.41 **2012 Fac PE RVU:** NA

RUC Recommendation: 1.71 **CPT Action (if applicable):** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

51727 **Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** **2010 Medicare Utilization Data:** 5,551

2007 Work RVU: **2012 Work RVU:** 2.11
2007 NF PE RVU: **2012 NF PE RVU:** 6.94
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 2.11 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51728 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** **2010 Medicare Utilization Data:** 78,550

2007 Work RVU: **2012 Work RVU:** 2.11
2007 NF PE RVU: **2012 NF PE RVU:** 6.94
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 2.11 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51729 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** **2010 Medicare Utilization Data:** 102,506

2007 Work RVU: **2012 Work RVU:** 2.51
2007 NF PE RVU: **2012 NF PE RVU:** 7.32
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 2.51 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51736 **Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 11 **Specialty Developing Recommendation:** AUA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 10,546

2007 Work RVU: 0.61 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.67 **2012 NF PE RVU:** 0.45
2007 Fac PE RVU: 0.67 **2012 Fac PE RVU:** NA

RUC Recommendation: 0.17 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51741 **Complex uroflowmetry (eg, calibrated electronic equipment)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 11 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 631,519

2007 Work RVU: 1.14 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.91 **2012 NF PE RVU:** 0.55
2007 Fac PE RVU: 0.91 **2012 Fac PE RVU:** NA

RUC Recommendation: 0.17 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51772 **Deleted from CPT**

Global: **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.61 **2012 Work RVU:**
2007 NF PE RVU: 5.44 **2012 NF PE RVU:**
2007 Fac PE RVU: 5.44 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

51795 **Deleted from CPT**

Global: **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.53 **2012 Work RVU:**
2007 NF PE RVU: 7.15 **2012 NF PE RVU:**
2007 Fac PE RVU: 7.15 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

51797 **Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2010 Medicare Utilization Data:** 156,207

2007 Work RVU: 1.60 **2012 Work RVU:** 0.8
2007 NF PE RVU: 5.55 **2012 NF PE RVU:** 2.77
2007 Fac PE RVU: 5.55 **2012 Fac PE RVU:** NA

RUC Recommendation: 0.80 **CPT Action (if applicable):** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

52000 **Cystourethroscopy (separate procedure)**

Global: 000 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 908,545

2007 Work RVU: 2.23 **2012 Work RVU:** 2.23
2007 NF PE RVU: 3.4 **2012 NF PE RVU:** 3.63
2007 Fac PE RVU: 0.91 **2012 Fac PE RVU:** 1.28

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2010 Medicare Utilization Data:** 21,170

2007 Work RVU: 3.70 **2012 Work RVU:** 3.7
2007 NF PE RVU: 33.55 **2012 NF PE RVU:** 14.77
2007 Fac PE RVU: 1.47 **2012 Fac PE RVU:** 1.96

RUC Recommendation: 3.50. CPT Assistant article published.

CPT Action (if applicable):

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

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

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 54,400

2007 Work RVU: 3.14 **2012 Work RVU:** 3.14
2007 NF PE RVU: 32.11 **2012 NF PE RVU:** 16.50
2007 Fac PE RVU: 1.28 **2012 Fac PE RVU:** 1.57

RUC Recommendation: 4.05. CPT Assistant article published.

CPT Action (if applicable):

Result: Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

52234 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 25,704

2007 Work RVU: 4.62 **2012 Work RVU:** 4.62
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.83 **2012 Fac PE RVU:** 2.24

RUC Recommendation: 4.62

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

52235 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2010 Medicare Utilization Data:** 30,520

2007 Work RVU: 5.44 **2012 Work RVU:** 5.44
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.13 **2012 Fac PE RVU:** 2.59

RUC Recommendation: 5.44

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52240 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 24,006

2007 Work RVU: 9.71 **2012 Work RVU:** 9.71
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.6 **2012 Fac PE RVU:** 4.29

RUC Recommendation: 8.75 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52281 **Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 38 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 111,095

2007 Work RVU: 2.80 **2012 Work RVU:** 2.75
2007 NF PE RVU: 6.65 **2012 NF PE RVU:** 5.31
2007 Fac PE RVU: 1.21 **2012 Fac PE RVU:** 1.50

RUC Recommendation: 2.80 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

52332 **Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 38 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 140,493

2007 Work RVU: 2.83 **2012 Work RVU:** 2.82
2007 NF PE RVU: 7.42 **2012 NF PE RVU:** 11.83
2007 Fac PE RVU: 1.19 **2012 Fac PE RVU:** 1.52

RUC Recommendation: 2.83 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52341 **Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2010 Medicare Utilization Data:** 2,325

2007 Work RVU: 6.11 **2012 Work RVU:** 5.35
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.44 **2012 Fac PE RVU:** 2.72

RUC Recommendation: 5.35 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52342 **Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2010 Medicare Utilization Data:** 297

2007 Work RVU: 6.61 **2012 Work RVU:** 5.85
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.59 **2012 Fac PE RVU:** 2.92

RUC Recommendation: 5.85 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52343 **Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2010 Medicare Utilization Data:** 33

2007 Work RVU: 7.31 **2012 Work RVU:** 6.55
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.84 **2012 Fac PE RVU:** 3.20

RUC Recommendation: 6.55 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52344 **Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,654

2007 Work RVU: 7.81 **2012 Work RVU:** 7.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.09 **2012 Fac PE RVU:** 3.56

RUC Recommendation: 7.05 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52345 **Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2010 Medicare Utilization Data:** 487

2007 Work RVU: 8.31 **2012 Work RVU:** 7.55
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.27 **2012 Fac PE RVU:** 3.76

RUC Recommendation: 7.55 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52346 **Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2010 Medicare Utilization Data:** 114

2007 Work RVU: 9.34 **2012 Work RVU:** 8.58
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.62 **2012 Fac PE RVU:** 4.19

RUC Recommendation: 8.58 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52351 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 19,303

2007 Work RVU: 5.85 **2012 Work RVU:** 5.85
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.36 **2012 Fac PE RVU:** 2.91

RUC Recommendation: 5.75 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52352 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 16,589

2007 Work RVU: 6.87 **2012 Work RVU:** 6.87
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.77 **2012 Fac PE RVU:** 3.41

RUC Recommendation: 6.75 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52353 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2010 Medicare Utilization Data:** 35,333

2007 Work RVU: 7.96 **2012 Work RVU:** 7.96
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.14 **2012 Fac PE RVU:** 3.84

RUC Recommendation: 7.88 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52354 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 6,876

2007 Work RVU: 7.33 **2012 Work RVU:** 7.33
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.94 **2012 Fac PE RVU:** 3.59

RUC Recommendation: 8.58 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

52355 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 934

2007 Work RVU: 8.81 **2012 Work RVU:** 8.81
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.44 **2012 Fac PE RVU:** 4.18

RUC Recommendation: 10.00 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

52400 **Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 491

2007 Work RVU: 10.06 **2012 Work RVU:** 8.69
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.18 **2012 Fac PE RVU:** 4.67

RUC Recommendation: 8.69 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52500 **Transurethral resection of bladder neck (separate procedure)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,914

2007 Work RVU: 9.39 **2012 Work RVU:** 8.14
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.52 **2012 Fac PE RVU:** 5.55

RUC Recommendation: 8.14 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52640 **Transurethral resection; of postoperative bladder neck contracture** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,979

2007 Work RVU: 6.89 **2012 Work RVU:** 4.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.35 **2012 Fac PE RVU:** 3.98

RUC Recommendation: 4.79 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

52648 **Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)** **Global:** 090 **Issue:** Laser Surgery of Prostate **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 30,107

2007 Work RVU: 12.00 **2012 Work RVU:** 12.15
2007 NF PE RVU: 66.1 **2012 NF PE RVU:** 44.70
2007 Fac PE RVU: 5.44 **2012 Fac PE RVU:** 7.10

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

53445 **Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,915

2007 Work RVU: 15.21 **2012 Work RVU:** 13
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.55 **2012 Fac PE RVU:** 8.39

RUC Recommendation: 13.00 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

53850 **Transurethral destruction of prostate tissue; by microwave thermotherapy** **Global:** **Issue:** Transurethral Destruction of Prostate Tissue **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 43 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 10.08 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

54405 **Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,328

2007 Work RVU: 14.39 **2012 Work RVU:** 14.52
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.51 **2012 Fac PE RVU:** 8.03

RUC Recommendation: 14.39 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

54410 **Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,269

2007 Work RVU: 16.48 **2012 Work RVU:** 15.18
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.35 **2012 Fac PE RVU:** 8.83

RUC Recommendation: 15.18 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

54520 **Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach** **Global:** 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,208

2007 Work RVU: 5.25 **2012 Work RVU:** 5.3
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.03 **2012 Fac PE RVU:** 3.80

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

54530 **Orchiectomy, radical, for tumor; inguinal approach**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,285

2007 Work RVU: 9.31 **2012 Work RVU:** 8.46
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.72 **2012 Fac PE RVU:** 5.68

RUC Recommendation: 8.46 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55866 **Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed**

Global: 090 **Issue:** Lap Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 14 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 12,665

2007 Work RVU: 32.25 **2012 Work RVU:** 32.06
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.87 **2012 Fac PE RVU:** 16.13

RUC Recommendation: 32.06 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55873 **Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**

Global: 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 25 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,703

2007 Work RVU: 20.25 **2012 Work RVU:** 13.6
2007 NF PE RVU: NA **2012 NF PE RVU:** 182.22
2007 Fac PE RVU: 9.59 **2012 Fac PE RVU:** 8.81

RUC Recommendation: 13.45 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

56515 **Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)**

Global: 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,864

2007 Work RVU: 3.03 **2012 Work RVU:** 3.08
2007 NF PE RVU: 2.5 **2012 NF PE RVU:** 3.10
2007 Fac PE RVU: 1.79 **2012 Fac PE RVU:** 2.35

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

56620 **Vulvectomy simple; partial** **Global:** 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** D **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,361

2007 Work RVU: 8.44 **2012 Work RVU:** 7.53
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.7 **2012 Fac PE RVU:** 6.24

RUC Recommendation: 7.35 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57155 **Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy** **Global:** 000 **Issue:** Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 12 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,266

2007 Work RVU: 6.79 **2012 Work RVU:** 5.4
2007 NF PE RVU: NA **2012 NF PE RVU:** 6.77
2007 Fac PE RVU: 4.3 **2012 Fac PE RVU:** 2.32

RUC Recommendation: 5.40 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57156 **Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy** **Global:** 000 **Issue:** Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 12 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2.69
2007 NF PE RVU: **2012 NF PE RVU:** 2.67
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.24

RUC Recommendation: 2.69 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57287 **Removal or revision of sling for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 2,127

2007 Work RVU: 11.49 **2012 Work RVU:** 11.15
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.73 **2012 Fac PE RVU:** 7.61

RUC Recommendation: 10.97 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57288 **Sling operation for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** O **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 47,685

2007 Work RVU: 14.01 **2012 Work RVU:** 12.13
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.21 **2012 Fac PE RVU:** 7.44

RUC Recommendation: 12.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58555 **Hysteroscopy, diagnostic (separate procedure)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2010 Medicare Utilization Data:** 1,906

2007 Work RVU: 3.33 **2012 Work RVU:** 3.33
2007 NF PE RVU: 2.32 **2012 NF PE RVU:** 4.67
2007 Fac PE RVU: 1.47 **2012 Fac PE RVU:** 1.78

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

58558 **Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2010 Medicare Utilization Data:** 38,647

2007 Work RVU: 4.74 **2012 Work RVU:** 4.74
2007 NF PE RVU: 2.52 **2012 NF PE RVU:** 5.73
2007 Fac PE RVU: 2.05 **2012 Fac PE RVU:** 2.43

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

58562 **Hysteroscopy, surgical; with removal of impacted foreign body** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2010 Medicare Utilization Data:** 134

2007 Work RVU: 5.20 **2012 Work RVU:** 5.2
2007 NF PE RVU: 2.63 **2012 NF PE RVU:** 5.65
2007 Fac PE RVU: 2.21 **2012 Fac PE RVU:** 2.59

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58563 **Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2010 Medicare Utilization Data:** 6,112

2007 Work RVU: 6.16 **2012 Work RVU:** 6.16
2007 NF PE RVU: 51.38 **2012 NF PE RVU:** 43.97
2007 Fac PE RVU: 2.58 **2012 Fac PE RVU:** 3.04

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

58660 **Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,833

2007 Work RVU: 11.54 **2012 Work RVU:** 11.59
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.07 **2012 Fac PE RVU:** 6.43

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

58661 **Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)**

Global: 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2010 Medicare Utilization Data:** 9,974

2007 Work RVU: 11.30 **2012 Work RVU:** 11.35
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.84 **2012 Fac PE RVU:** 5.92

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

59400 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 3,985

2007 Work RVU: 26.80 **2012 Work RVU:** 32.16
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 15.06 **2012 Fac PE RVU:** 21.18

RUC Recommendation: 32.69 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59409 **Vaginal delivery only (with or without episiotomy and/or forceps);** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,581

2007 Work RVU: 13.48 **2012 Work RVU:** 14.37
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.91 **2012 Fac PE RVU:** 6.15

RUC Recommendation: 14.37 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59410 **Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,266

2007 Work RVU: 15.29 **2012 Work RVU:** 18.01
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.96 **2012 Fac PE RVU:** 8.14

RUC Recommendation: 18.54 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59412 **External cephalic version, with or without tocolysis** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 31

2007 Work RVU: 1.71 **2012 Work RVU:** 1.71
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.77 **2012 Fac PE RVU:** 0.92

RUC Recommendation: 1.71 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59414 **Delivery of placenta (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 48

2007 Work RVU: 1.61 **2012 Work RVU:** 1.61
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.59 **2012 Fac PE RVU:** 0.69

RUC Recommendation: 1.61 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59425 **Antepartum care only; 4-6 visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 818

2007 Work RVU: 6.22 **2012 Work RVU:** 6.31
2007 NF PE RVU: 4.21 **2012 NF PE RVU:** 5.58
2007 Fac PE RVU: 1.81 **2012 Fac PE RVU:** 2.66

RUC Recommendation: 6.31 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59426 **Antepartum care only; 7 or more visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 856

2007 Work RVU: 11.04 **2012 Work RVU:** 11.16
2007 NF PE RVU: 7.6 **2012 NF PE RVU:** 10.21
2007 Fac PE RVU: 3.17 **2012 Fac PE RVU:** 4.72

RUC Recommendation: 11.16 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59430 **Postpartum care only (separate procedure)**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 1,459

2007 Work RVU: 2.13 **2012 Work RVU:** 2.47
2007 NF PE RVU: 1.19 **2012 NF PE RVU:** 2.18
2007 Fac PE RVU: 0.88 **2012 Fac PE RVU:** 1.07

RUC Recommendation: 2.47 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59510 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 3,242

2007 Work RVU: 30.34 **2012 Work RVU:** 35.64
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 16.92 **2012 Fac PE RVU:** 23.29

RUC Recommendation: 36.17 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59514 **Cesarean delivery only;** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** **2010 Medicare Utilization Data:** 1,205

2007 Work RVU: 15.95 **2012 Work RVU:** 16.13
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.78 **2012 Fac PE RVU:** 6.97

RUC Recommendation: 16.13 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59515 **Cesarean delivery only; including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 1,204

2007 Work RVU: 18.26 **2012 Work RVU:** 21.47
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.43 **2012 Fac PE RVU:** 10.16

RUC Recommendation: 22.00 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59610 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 91

2007 Work RVU: 28.21 **2012 Work RVU:** 33.87
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 15.52 **2012 Fac PE RVU:** 21.84

RUC Recommendation: 34.40 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59612 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 29

2007 Work RVU: 15.04 **2012 Work RVU:** 16.09
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.6 **2012 Fac PE RVU:** 6.86

RUC Recommendation: 16.09 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59614 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 29

2007 Work RVU: 16.59 **2012 Work RVU:** 19.73
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.49 **2012 Fac PE RVU:** 8.72

RUC Recommendation: 20.26 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59618 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 34

2007 Work RVU: 31.78 **2012 Work RVU:** 36.16
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 17.74 **2012 Fac PE RVU:** 23.63

RUC Recommendation: 36.69 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59620 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 23

2007 Work RVU: 17.50 **2012 Work RVU:** 16.66
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.27 **2012 Fac PE RVU:** 7.27

RUC Recommendation: 16.66 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59622 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2010 Medicare Utilization Data:** 5

2007 Work RVU: 19.70 **2012 Work RVU:** 22
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 8.14 **2012 Fac PE RVU:** 10.57

RUC Recommendation: 22.53 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60220 **Total thyroid lobectomy, unilateral; with or without isthmusectomy** **Global:** 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 8,652

2007 Work RVU: 12.29 **2012 Work RVU:** 11.19
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.96 **2012 Fac PE RVU:** 7.89

RUC Recommendation: 12.29 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

60225 **Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy** **Global:** 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 792

2007 Work RVU: 14.67 **2012 Work RVU:** 14.79
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.22 **2012 Fac PE RVU:** 10.02

RUC Recommendation: 14.67 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

60520 **Thymectomy, partial or total; transcervical approach (separate procedure)** **Global:** 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2010 Medicare Utilization Data:** 305

2007 Work RVU: 17.07 **2012 Work RVU:** 17.16
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.95 **2012 Fac PE RVU:** 9.82

RUC Recommendation: Request further information from CMS **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60521 **Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: November 2011 **2010 Medicare Utilization Data:** 334

2007 Work RVU: 19.11 **2012 Work RVU:** 19.18

2007 NF PE RVU: NA **2012 NF PE RVU:** NA

2007 Fac PE RVU: 9.22 **2012 Fac PE RVU:** 10.20

RUC Recommendation: Request further information from CMS

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

60522 **Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: November 2011 **2010 Medicare Utilization Data:** 131

2007 Work RVU: 23.37 **2012 Work RVU:** 23.48

2007 NF PE RVU: NA **2012 NF PE RVU:** NA

2007 Fac PE RVU: 10.89 **2012 Fac PE RVU:** 12.29

RUC Recommendation: Request further information from CMS

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

61781 **Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS

First Identified: **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.75

2007 NF PE RVU: **2012 NF PE RVU:** NA

2007 Fac PE RVU: **2012 Fac PE RVU:** 1.98

RUC Recommendation: 3.75

CPT Action (if applicable): October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61782 **Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAO-HNS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.18
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.68

RUC Recommendation: 3.18 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61783 **Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.75
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.98

RUC Recommendation: 3.75 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61793 **Deleted from CPT**

Global: **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: 17.75 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 10.08 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61795 **Deleted from CPT** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 22,554

2007 Work RVU: 4.03 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 1.87 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

61796 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 4,956

2007 Work RVU: **2012 Work RVU:** 13.93
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 10.69

RUC Recommendation: 15.50 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61797 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 3,509

2007 Work RVU: **2012 Work RVU:** 3.48
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.79

RUC Recommendation: 3.48 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61798 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 3,157

2007 Work RVU: **2012 Work RVU:** 19.85
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 12.98

RUC Recommendation: 19.75 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61799 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 588

2007 Work RVU: **2012 Work RVU:** 4.81
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.48

RUC Recommendation: 4.81 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61800 **Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 16 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 5,082

2007 Work RVU: **2012 Work RVU:** 2.25
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.51

RUC Recommendation: 2.25 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61885 **Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array**

Global: 090 **Issue:** Vagal Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,020

2007 Work RVU: 7.37 **2012 Work RVU:** 6.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.85 **2012 Fac PE RVU:** 7.57

RUC Recommendation: 6.44 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62263 **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days**

Global: 010 **Issue:** Epidual Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 66 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,023

2007 Work RVU: 6.41 **2012 Work RVU:** 5
2007 NF PE RVU: 11.78 **2012 NF PE RVU:** 14.68
2007 Fac PE RVU: 3.11 **2012 Fac PE RVU:** 4.61

RUC Recommendation: 6.54 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

62281 **Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic**

Global: 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 625

2007 Work RVU: 2.66 **2012 Work RVU:** 2.66
2007 NF PE RVU: 5.16 **2012 NF PE RVU:** 4.43
2007 Fac PE RVU: 0.89 **2012 Fac PE RVU:** 1.56

RUC Recommendation: Remove 99238 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Q&A May 2010

62287 **Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar**

Global: 090 **Issue:** Percutaneous Diskectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 744

2007 Work RVU: 8.88 **2012 Work RVU:** 9.03
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.18 **2012 Fac PE RVU:** 6.61

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62290 **Injection procedure for discography, each level; lumbar**

Global: 000 **Issue:** Injection for discography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 19,379

2007 Work RVU: 3.00 **2012 Work RVU:** 3
2007 NF PE RVU: 6.43 **2012 NF PE RVU:** 6.81
2007 Fac PE RVU: 1.31 **2012 Fac PE RVU:** 1.78

RUC Recommendation: 3.00, CPT Assistant article published.

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2011

62310 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 184,739

2007 Work RVU: 1.91 **2012 Work RVU:** 1.91
2007 NF PE RVU: 4.35 **2012 NF PE RVU:** 5.18
2007 Fac PE RVU: 0.63 **2012 Fac PE RVU:** 1.08

RUC Recommendation: Survey for work and PE for the October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

62311 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 888,396

2007 Work RVU: 1.54 **2012 Work RVU:** 1.54
2007 NF PE RVU: 4.35 **2012 NF PE RVU:** 4.48
2007 Fac PE RVU: 0.58 **2012 Fac PE RVU:** 0.92

RUC Recommendation: Survey for work and PE for the October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62318 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 43,417

2007 Work RVU: 2.04 **2012 Work RVU:** 2.04
2007 NF PE RVU: 5.09 **2012 NF PE RVU:** 5.18
2007 Fac PE RVU: 0.61 **2012 Fac PE RVU:** 0.79

RUC Recommendation: Survey for work and PE for the October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

62319 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 39,785

2007 Work RVU: 1.87 **2012 Work RVU:** 1.87
2007 NF PE RVU: 4.45 **2012 NF PE RVU:** 3.41
2007 Fac PE RVU: 0.58 **2012 Fac PE RVU:** 0.82

RUC Recommendation: Survey for work and PE for the October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

62350 **Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 6,433

2007 Work RVU: 8.04 **2012 Work RVU:** 6.05
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4 **2012 Fac PE RVU:** 4.63

RUC Recommendation: 6.05

CPT Action (if applicable):

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62355 **Removal of previously implanted intrathecal or epidural catheter** **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,269

2007 Work RVU: 6.60 **2012 Work RVU:** 3.55
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.27 **2012 Fac PE RVU:** 3.52

RUC Recommendation: 4.35 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62360 **Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir** **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 516

2007 Work RVU: 3.68 **2012 Work RVU:** 4.33
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 2.87 **2012 Fac PE RVU:** 3.89

RUC Recommendation: 4.33 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62361 **Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump** **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 146

2007 Work RVU: 6.59 **2012 Work RVU:** 5
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.94 **2012 Fac PE RVU:** 4.32

RUC Recommendation: 5.65 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62362 **Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 6,268

2007 Work RVU: 8.58 **2012 Work RVU:** 5.6
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.46 **2012 Fac PE RVU:** 4.72

RUC Recommendation: 6.10 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62365 **Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,190

2007 Work RVU: 6.57 **2012 Work RVU:** 3.93
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.65 **2012 Fac PE RVU:** 3.98

RUC Recommendation: 4.65 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62367 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 12,783

2007 Work RVU: 0.48 **2012 Work RVU:** 0.48
2007 NF PE RVU: 0.56 **2012 NF PE RVU:** 0.67
2007 Fac PE RVU: 0.1 **2012 Fac PE RVU:** 0.20

RUC Recommendation: 0.48 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62368 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 186,812

2007 Work RVU: 0.75 **2012 Work RVU:** 0.67
2007 NF PE RVU: 0.67 **2012 NF PE RVU:** 0.91
2007 Fac PE RVU: 0.17 **2012 Fac PE RVU:** 0.29

RUC Recommendation: 0.67 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62369 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.67
2007 NF PE RVU: **2012 NF PE RVU:** 2.95
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.32

RUC Recommendation: 0.67 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62370 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.9
2007 NF PE RVU: **2012 NF PE RVU:** 2.87
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.42

RUC Recommendation: 1.10 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63047 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar**

Global: 090 **Issue:** RAW Review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 81,701

2007 Work RVU: 15.22 **2012 Work RVU:** 15.37
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.79 **2012 Fac PE RVU:** 12.83

RUC Recommendation: Survey for physician work only (no PE) for the October 2012 RUC meeting.

CPT Action (if applicable): **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

63048 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: January 2012 **2010 Medicare Utilization Data:** 121,058

2007 Work RVU: 3.47 **2012 Work RVU:** 3.47
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.58 **2012 Fac PE RVU:** 1.84

RUC Recommendation: Survey for physician work only (no PE) for the October 2012 RUC meeting.

CPT Action (if applicable): **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

63056 **Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)**

Global: 090 **Issue:** Decompression of Spinal Cord **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** NASS, AANS

First Identified: October 2008 **2010 Medicare Utilization Data:** 7,343

2007 Work RVU: 21.73 **2012 Work RVU:** 21.86
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.31 **2012 Fac PE RVU:** 15.75

RUC Recommendation: Refer to CPT

CPT Action (if applicable): February 2010 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

Status Report: CMS Requests and Relativity Assessment Issues

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Global: 090 **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 28,905

2007 Work RVU: 19.47 **2012 Work RVU:** 19.6
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.87 **2012 Fac PE RVU:** 15.02

RUC Recommendation: 17.69 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63076 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2010 Medicare Utilization Data:** 22,851

2007 Work RVU: 4.04 **2012 Work RVU:** 4.04
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.93 **2012 Fac PE RVU:** 2.14

RUC Recommendation: 19.60 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63620 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion**

Global: 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 418

2007 Work RVU: **2012 Work RVU:** 15.6
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 11.32

RUC Recommendation: 15.50 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63621 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 81

2007 Work RVU: **2012 Work RVU:** 4
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.06

RUC Recommendation: 4.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63650 **Percutaneous implantation of neurostimulator electrode array, epidural**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 68 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 40,421

2007 Work RVU: 7.57 **2012 Work RVU:** 7.15
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.11 **2012 Fac PE RVU:** 4.76

RUC Recommendation: 7.20 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63655 **Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 5,338

2007 Work RVU: 11.43 **2012 Work RVU:** 10.92
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.15 **2012 Fac PE RVU:** 10.15

RUC Recommendation: 11.43 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63660 **Deleted from CPT**

Global: **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: 6.87 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 3.54 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

63661 **Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2010 Medicare Utilization Data:** 4,207

2007 Work RVU: **2012 Work RVU:** 5.08
2007 NF PE RVU: **2012 NF PE RVU:** 11.88
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.77

RUC Recommendation: 5.02 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63662 **Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2010 Medicare Utilization Data:** 911

2007 Work RVU: **2012 Work RVU:** 11
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 10.57

RUC Recommendation: 10.84 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63663 **Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2010 Medicare Utilization Data:** 1,173

2007 Work RVU: **2012 Work RVU:** 7.75
2007 NF PE RVU: **2012 NF PE RVU:** 16.29
2007 Fac PE RVU: **2012 Fac PE RVU:** 5.11

RUC Recommendation: 7.68 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63664 **Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2010 Medicare Utilization Data:** 579

2007 Work RVU: **2012 Work RVU:** 11.52
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 10.54

RUC Recommendation: 11.34 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63685 **Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 68 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 12,177

2007 Work RVU: 7.87 **2012 Work RVU:** 5.19
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.03 **2012 Fac PE RVU:** 4.54

RUC Recommendation: 6.05 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63688 **Revision or removal of implanted spinal neurostimulator pulse generator or receiver**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 4,540

2007 Work RVU: 6.10 **2012 Work RVU:** 5.3
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.56 **2012 Fac PE RVU:** 4.51

RUC Recommendation: 5.25 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64415 **Injection, anesthetic agent; brachial plexus, single**

Global: 000 **Issue:** Injection of Anesthetic Agent - Nerve **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2009 **Tab** 16 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 108,601

2007 Work RVU: 1.48 **2012 Work RVU:** 1.48
2007 NF PE RVU: 2.47 **2012 NF PE RVU:** 2.06
2007 Fac PE RVU: 0.43 **2012 Fac PE RVU:** 0.37

RUC Recommendation: 1.48, CPT Assistant Article and review in 2 years (Oct 2012) **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 20

64416 **Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 11,164

2007 Work RVU: 3.85 **2012 Work RVU:** 1.81
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.74 **2012 Fac PE RVU:** 0.43

RUC Recommendation: 1.81 **CPT Action (if applicable):** February 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64445 **Injection, anesthetic agent; sciatic nerve, single**

Global: 000 **Issue:** Injection of Anesthetic Agent - Nerve **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2009 **Tab** 16 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 100,047

2007 Work RVU: 1.48 **2012 Work RVU:** 1.48
2007 NF PE RVU: 2.42 **2012 NF PE RVU:** 2.36
2007 Fac PE RVU: 0.51 **2012 Fac PE RVU:** 0.54

RUC Recommendation: 1.48, CPT Assistant Article and review in 2 years (Oct 2012)

CPT Action (if applicable):

Result:

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 20

64446 **Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 6,887

2007 Work RVU: 3.61 **2012 Work RVU:** 1.81
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.9 **2012 Fac PE RVU:** 0.45

RUC Recommendation: 1.81

CPT Action (if applicable): February 2008

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64447 **Injection, anesthetic agent; femoral nerve, single**

Global: 000 **Issue:** Injection of Anesthetic Agent - Nerve **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2009 **Tab** 16 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 104,974

2007 Work RVU: 1.50 **2012 Work RVU:** 1.5
2007 NF PE RVU: NA **2012 NF PE RVU:** 2.04
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** 0.34

RUC Recommendation: 1.50, CPT Assistant Article and review in 2 years (Oct 2012)

CPT Action (if applicable):

Result:

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 20

Status Report: CMS Requests and Relativity Assessment Issues

64448 **Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 66,283

2007 Work RVU: 3.36 **2012 Work RVU:** 1.63
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.73 **2012 Fac PE RVU:** 0.39

RUC Recommendation: 1.63 **CPT Action (if applicable):** February 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64449 **Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 5,416

2007 Work RVU: 3.24 **2012 Work RVU:** 1.81
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.84 **2012 Fac PE RVU:** 0.53

RUC Recommendation: 1.81 **CPT Action (if applicable):** February 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64450 **Injection, anesthetic agent; other peripheral nerve or branch**

Global: 000 **Issue:** Injection - Anesthetic Agent **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 24 **Specialty Developing Recommendation:** ASA, AAPM, APMA, ASIPP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 268,828

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 1.25 **2012 NF PE RVU:** 1.72
2007 Fac PE RVU: 0.49 **2012 Fac PE RVU:** 0.65

RUC Recommendation: 0.75 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:**

64470 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.85 **2012 Work RVU:**
2007 NF PE RVU: 6.37 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.71 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64472 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.29 **2012 Work RVU:**
2007 NF PE RVU: 2.05 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.34 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64475 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.41 **2012 Work RVU:**
2007 NF PE RVU: 6.07 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.62 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64476 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.98 **2012 Work RVU:**
2007 NF PE RVU: 1.86 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.24 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64479 **Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 43,666

2007 Work RVU: 2.20 **2012 Work RVU:** 2.29
2007 NF PE RVU: 6.55 **2012 NF PE RVU:** 5.10
2007 Fac PE RVU: 0.87 **2012 Fac PE RVU:** 1.38

RUC Recommendation: 2.29 **CPT Action (if applicable):** June 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64480 **Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 32,822

2007 Work RVU: 1.54 **2012 Work RVU:** 1.2
2007 NF PE RVU: 2.5 **2012 NF PE RVU:** 2.29
2007 Fac PE RVU: 0.45 **2012 Fac PE RVU:** 0.58

RUC Recommendation: 1.20 **CPT Action (if applicable):** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64483 **Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level** **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 803,663

2007 Work RVU: 1.90 **2012 Work RVU:** 1.9
2007 NF PE RVU: 6.86 **2012 NF PE RVU:** 5.05
2007 Fac PE RVU: 0.81 **2012 Fac PE RVU:** 1.23

RUC Recommendation: 1.90 **CPT Action (if applicable):** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64484 **Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 422,276

2007 Work RVU: 1.33 **2012 Work RVU:** 1
2007 NF PE RVU: 2.86 **2012 NF PE RVU:** 1.86
2007 Fac PE RVU: 0.36 **2012 Fac PE RVU:** 0.47

RUC Recommendation: 1.00 **CPT Action (if applicable):** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64490 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2010 Medicare Utilization Data:** 156,447

2007 Work RVU: **2012 Work RVU:** 1.82
2007 NF PE RVU: **2012 NF PE RVU:** 3.92
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.24

RUC Recommendation: 1.82 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64491 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2010 Medicare Utilization Data:** 139,473

2007 Work RVU: **2012 Work RVU:** 1.16
2007 NF PE RVU: **2012 NF PE RVU:** 1.62
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.55

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64492 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2010 Medicare Utilization Data:** 99,009

2007 Work RVU: **2012 Work RVU:** 1.16
2007 NF PE RVU: **2012 NF PE RVU:** 1.64
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.57

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64493 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2010 Medicare Utilization Data:** 565,603

2007 Work RVU: **2012 Work RVU:** 1.52
2007 NF PE RVU: **2012 NF PE RVU:** 3.66
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.08

RUC Recommendation: 1.52 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64494 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2010 Medicare Utilization Data:** 496,403

2007 Work RVU: **2012 Work RVU:** 1
2007 NF PE RVU: **2012 NF PE RVU:** 1.56
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.46

RUC Recommendation: 1.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64495 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2010 Medicare Utilization Data:** 312,363

2007 Work RVU: **2012 Work RVU:** 1
2007 NF PE RVU: **2012 NF PE RVU:** 1.58
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.49

RUC Recommendation: 1.00 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64510 **Injection, anesthetic agent; stellate ganglion (cervical sympathetic)** **Global:** 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2010 Medicare Utilization Data:** 7,923

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 3.06 **2012 NF PE RVU:** 2.65
2007 Fac PE RVU: 0.49 **2012 Fac PE RVU:** 0.81

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

64520 **Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)** **Global:** 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2010 Medicare Utilization Data:** 20,104

2007 Work RVU: 1.35 **2012 Work RVU:** 1.35
2007 NF PE RVU: 4.5 **2012 NF PE RVU:** 4.35
2007 Fac PE RVU: 0.54 **2012 Fac PE RVU:** 0.90

RUC Recommendation: PE Review - no change **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

64555 **Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)** **Global:** 010 **Issue:** Neurostimulators **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** ASA, AAPM, ASIPP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 40,366

2007 Work RVU: 2.29 **2012 Work RVU:** 2.32
2007 NF PE RVU: 2.96 **2012 NF PE RVU:** 3.23
2007 Fac PE RVU: 1.23 **2012 Fac PE RVU:** 1.75

RUC Recommendation: Review September 2014. CPT Assistant article published. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009

Status Report: CMS Requests and Relativity Assessment Issues

64561 **Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)** **Global:** 010 **Issue:** Neurostimulators **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ISIS, AUA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 14,811

2007 Work RVU: 7.07 **2012 Work RVU:** 7.15
2007 NF PE RVU: 27.51 **2012 NF PE RVU:** 18.25
2007 Fac PE RVU: 3.05 **2012 Fac PE RVU:** 3.90

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

64568 **Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator** **Global:** 090 **Issue:** Vagus Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 9
2007 NF PE RVU: **2012 NF PE RVU:** NA
2007 Fac PE RVU: **2012 Fac PE RVU:** 8.50

RUC Recommendation: 11.19 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64573 **Deleted from CPT** **Global:** 090 **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 695

2007 Work RVU: 8.15 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 5.31 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64581 **Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 17 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 8,199

2007 Work RVU: 14.15 **2012 Work RVU:** 12.2
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.73 **2012 Fac PE RVU:** 6.32

RUC Recommendation: 12.20 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64622 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level**

Global: 010 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2010 Medicare Utilization Data:** 137,642

2007 Work RVU: 3.02 **2012 Work RVU:**
2007 NF PE RVU: 6.82 **2012 NF PE RVU:**
2007 Fac PE RVU: 1.34 **2012 Fac PE RVU:**

RUC Recommendation: PE Review - no change **CPT Action (if applicable):** June 2008 and Feb 2011 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

64623 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2010 Medicare Utilization Data:** 296,544

2007 Work RVU: 0.99 **2012 Work RVU:**
2007 NF PE RVU: 2.62 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.22 **2012 Fac PE RVU:**

RUC Recommendation: 0.99 **CPT Action (if applicable):** June 2008 and Feb 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

64626 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level**

Global: 010 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2010 Medicare Utilization Data:** 30,245

2007 Work RVU: 3.82 **2012 Work RVU:**
2007 NF PE RVU: 6.99 **2012 NF PE RVU:**
2007 Fac PE RVU: 1.93 **2012 Fac PE RVU:**

RUC Recommendation: PE Review - no change **CPT Action (if applicable):** June 2008 and Feb 2011 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64627 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2010 Medicare Utilization Data:** 65,215

2007 Work RVU: 1.16 **2012 Work RVU:**
2007 NF PE RVU: 3.98 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.26 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64640 **Destruction by neurolytic agent; other peripheral nerve or branch**

Global: 010 **Issue:** Injection Treatment of Nerve **Screen:** Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 25 **Specialty Developing Recommendation:** ASAM AAPM, APMA, ASIPP **First Identified:** September 2007 **2010 Medicare Utilization Data:** 71,836

2007 Work RVU: 2.78 **2012 Work RVU:** 2.81
2007 NF PE RVU: 3.75 **2012 NF PE RVU:** 3.41
2007 Fac PE RVU: 1.75 **2012 Fac PE RVU:** 1.94

RUC Recommendation: 1.23. Remove 99238. **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64708 **Neuroplasty, major peripheral nerve, arm or leg, open; other than specified**

Global: 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,279

2007 Work RVU: 6.22 **2012 Work RVU:** 6.36
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.73 **2012 Fac PE RVU:** 7.02

RUC Recommendation: 6.36 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64712 **Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 795

2007 Work RVU: 7.98 **2012 Work RVU:** 8.07
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.86 **2012 Fac PE RVU:** 6.99

RUC Recommendation: Remove from screen **CPT Action (if applicable):** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64831 **Suture of digital nerve, hand or foot; 1 nerve** **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2010 Medicare Utilization Data:** 996

2007 Work RVU: 10.23 **2012 Work RVU:** 9.16
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7 **2012 Fac PE RVU:** 9.36

RUC Recommendation: 9.16 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65105 **Enucleation of eye; with implant, muscles attached to implant** **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 907

2007 Work RVU: 9.70 **2012 Work RVU:** 9.93
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.13 **2012 Fac PE RVU:** 13.28

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

65222 **Removal of foreign body, external eye; corneal, with slit lamp** **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 26 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2010 Medicare Utilization Data:** 32,848

2007 Work RVU: 0.93 **2012 Work RVU:** 0.93
2007 NF PE RVU: 0.87 **2012 NF PE RVU:** 1.14
2007 Fac PE RVU: 0.4 **2012 Fac PE RVU:** 0.64

RUC Recommendation: 0.93 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65285 **Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue**

Global: 090 **Issue:** Repair of Eye Wound **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 8 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 971

2007 Work RVU: 14.43 **2012 Work RVU:** 15.36
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.12 **2012 Fac PE RVU:** 14.48

RUC Recommendation: 16.00 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

65780 **Ocular surface reconstruction; amniotic membrane transplantation, multiple layers**

Global: 090 **Issue:** Ophthalmological Procedures **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2010 Medicare Utilization Data:** 3,062

2007 Work RVU: 10.43 **2012 Work RVU:** 10.73
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 10.04 **2012 Fac PE RVU:** 13.59

RUC Recommendation: Add to new technology list and review in 3 years (Sept 2014). CPT Assistant article published. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

65800 **Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous**

Global: 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 21 **Specialty Developing Recommendation:** AAO **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,783

2007 Work RVU: 1.91 **2012 Work RVU:** 1.91
2007 NF PE RVU: 1.71 **2012 NF PE RVU:** 2.16
2007 Fac PE RVU: 1.16 **2012 Fac PE RVU:** 1.64

RUC Recommendation: 1.53 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

65805 **Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous**

Global: 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 21 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2010 Medicare Utilization Data:** 36,275

2007 Work RVU: 1.91 **2012 Work RVU:** 1.91
2007 NF PE RVU: 2.07 **2012 NF PE RVU:** 2.56
2007 Fac PE RVU: 1.16 **2012 Fac PE RVU:** 1.64

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66761 **Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)** **Global:** 010 **Issue:** Iridotomy **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 14 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 79,902

2007 Work RVU: 4.87 **2012 Work RVU:** 3
2007 NF PE RVU: 5.49 **2012 NF PE RVU:** 5.62
2007 Fac PE RVU: 4.32 **2012 Fac PE RVU:** 4.03

RUC Recommendation: 3.00 **CPT Action (if applicable):** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66821 **Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)** **Global:** 090 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 549,620

2007 Work RVU: 3.32 **2012 Work RVU:** 3.42
2007 NF PE RVU: 4.05 **2012 NF PE RVU:** 5.63
2007 Fac PE RVU: 3.6 **2012 Fac PE RVU:** 5.09

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

66982 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage** **Global:** 090 **Issue:** Cataract Surgery **Screen:** High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 17 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 149,455

2007 Work RVU: 14.83 **2012 Work RVU:** 15.02
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 9.75 **2012 Fac PE RVU:** 13.63

RUC Recommendation: 11.08. CPT Assistant article published; Reduce to 2x99213 & 3x99212 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

Status Report: CMS Requests and Relativity Assessment Issues

66984 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)**

Global: 090 **Issue:** Cataract Surgery **Screen:** High IWPUT / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 17 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,636,937

2007 Work RVU: 10.36 **2012 Work RVU:** 10.52
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.24 **2012 Fac PE RVU:** 10.18

RUC Recommendation: 8.52 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67028 **Intravitreal injection of a pharmacologic agent (separate procedure)**

Global: 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: Jan11, Oct09 **Tab** 30 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,649,893

2007 Work RVU: 2.52 **2012 Work RVU:** 1.44
2007 NF PE RVU: 2.59 **2012 NF PE RVU:** 1.76
2007 Fac PE RVU: 1.42 **2012 Fac PE RVU:** 1.42

RUC Recommendation: 1.44 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67038 **Deleted from CPT**

Global: **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:**

2007 Work RVU: 23.30 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 15.16 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2007 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67039 **Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,859

2007 Work RVU: 16.39 **2012 Work RVU:** 16.74
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.94 **2012 Fac PE RVU:** 16.83

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

67040 **Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 11,485

2007 Work RVU: 19.23 **2012 Work RVU:** 19.61
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 13.41 **2012 Fac PE RVU:** 18.99

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

67107 **Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid**

Global: 090 **Issue:** Retinal Detachment **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,626

2007 Work RVU: 16.35 **2012 Work RVU:** 16.71
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 11.19 **2012 Fac PE RVU:** 16.31

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67108 **Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique**

Global: 090 **Issue:** Retinal Detachment **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 12,244

2007 Work RVU: 22.49 **2012 Work RVU:** 22.89
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 14.22 **2012 Fac PE RVU:** 20.67

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

67110 **Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)**

Global: 090 **Issue:** Retinal Detachment **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 3,061

2007 Work RVU: 10.02 **2012 Work RVU:** 10.25
2007 NF PE RVU: 9.99 **2012 NF PE RVU:** 13.51
2007 Fac PE RVU: 7.37 **2012 Fac PE RVU:** 10.82

RUC Recommendation: Remove 99238 **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

67210 **Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 119,485

2007 Work RVU: 9.35 **2012 Work RVU:** 6.36
2007 NF PE RVU: 6.48 **2012 NF PE RVU:** 8.09
2007 Fac PE RVU: 5.84 **2012 Fac PE RVU:** 7.51

RUC Recommendation: 6.36 **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67220 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 11,521

2007 Work RVU: 14.19 **2012 Work RVU:** 6.36
2007 NF PE RVU: 10.23 **2012 NF PE RVU:** 9.54
2007 Fac PE RVU: 8.9 **2012 Fac PE RVU:** 8.40

RUC Recommendation: 6.36 **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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67225 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)**

Global: ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 532

2007 Work RVU: 0.47 **2012 Work RVU:** 0.47
2007 NF PE RVU: 0.25 **2012 NF PE RVU:** 0.34
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:** 0.29

RUC Recommendation: 0.47 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67228 **Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 84,696

2007 Work RVU: 13.67 **2012 Work RVU:** 13.82
2007 NF PE RVU: 11.2 **2012 NF PE RVU:** 14.69
2007 Fac PE RVU: 8.43 **2012 Fac PE RVU:** 12.51

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

68040 **Expression of conjunctival follicles (eg, for trachoma)**

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2010 Medicare Utilization Data:** 6,184

2007 Work RVU: 0.85 **2012 Work RVU:** 0.85
2007 NF PE RVU: 0.69 **2012 NF PE RVU:** 0.92
2007 Fac PE RVU: 0.42 **2012 Fac PE RVU:** 0.58

RUC Recommendation: Refer to CPT for deletion. **CPT Action (if applicable):** February 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

68200 **Subconjunctival injection**

Global: 000 **Issue:** Subconjunctival Injection **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 28 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2010 Medicare Utilization Data:** 26,392

2007 Work RVU: 0.49 **2012 Work RVU:** 0.49
2007 NF PE RVU: 0.52 **2012 NF PE RVU:** 0.67
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.46

RUC Recommendation: 0.49 and Review Sept 2013. **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

68810 **Probing of nasolacrimal duct, with or without irrigation;** **Global:** 010 **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** L **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 32,031

2007 Work RVU: 2.63 **2012 Work RVU:** 2.15
2007 NF PE RVU: 3.62 **2012 NF PE RVU:** 4.54
2007 Fac PE RVU: 2.7 **2012 Fac PE RVU:** 3.02

RUC Recommendation: 2.09 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

69100 **Biopsy external ear** **Global:** 000 **Issue:** Biopsy of Ear **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 28 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2010 Medicare Utilization Data:** 99,482

2007 Work RVU: 0.81 **2012 Work RVU:** 0.81
2007 NF PE RVU: 1.75 **2012 NF PE RVU:** 2.10
2007 Fac PE RVU: 0.4 **2012 Fac PE RVU:** 0.54

RUC Recommendation: 0.81 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69200 **Removal foreign body from external auditory canal; without general anesthesia** **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 29 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 34,838

2007 Work RVU: 0.77 **2012 Work RVU:** 0.77
2007 NF PE RVU: 2.29 **2012 NF PE RVU:** 2.87
2007 Fac PE RVU: 0.56 **2012 Fac PE RVU:** 0.85

RUC Recommendation: 0.77 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69210 **Removal impacted cerumen (separate procedure), 1 or both ears** **Global:** 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,412,292

2007 Work RVU: 0.61 **2012 Work RVU:** 0.61
2007 NF PE RVU: 0.61 **2012 NF PE RVU:** 0.83
2007 Fac PE RVU: 0.21 **2012 Fac PE RVU:** 0.28

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69433 **Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia**

Global: 010 **Issue:** Tympanostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 30 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 42,826

2007 Work RVU: 1.54 **2012 Work RVU:** 1.57
2007 NF PE RVU: 3.09 **2012 NF PE RVU:** 4.28
2007 Fac PE RVU: 1.6 **2012 Fac PE RVU:** 2.15

RUC Recommendation: 1.57 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

69801 **Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal**

Global: 000 **Issue:** Labyrinthotomy **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 6,140

2007 Work RVU: 8.61 **2012 Work RVU:** 2.06
2007 NF PE RVU: NA **2012 NF PE RVU:** 3.66
2007 Fac PE RVU: 9.31 **2012 Fac PE RVU:** 4.00

RUC Recommendation: 2.06 **CPT Action (if applicable):** Feb 2010 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

69802 **Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy**

Global: 090 **Issue:** Labryinthotomy **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** **2010 Medicare Utilization Data:** 9

2007 Work RVU: 13.39 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 11.91 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** Feburary 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69930 **Cochlear device implantation, with or without mastoidectomy**

Global: 090 **Issue:** Cochlear Device Implantation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** M **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,930

2007 Work RVU: 17.60 **2012 Work RVU:** 17.73
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 14.06 **2012 Fac PE RVU:** 16.91

RUC Recommendation: 17.60 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70450 **Computed tomography, head or brain; without contrast material**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** AUR, ACR, ASNR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 5,077,781

2007 Work RVU: 0.85 **2012 Work RVU:** 0.85
2007 NF PE RVU: 4.91 **2012 NF PE RVU:** 4.52
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

70460 **Computed tomography, head or brain; with contrast material(s)**

Global: XXX **Issue:** **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 37,988

2007 Work RVU: 1.13 **2012 Work RVU:** 1.13
2007 NF PE RVU: 6.06 **2012 NF PE RVU:** 5.89
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70470 **Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Head/Brain **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 23 **Specialty Developing Recommendation:** ACR, ASNR, AUR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 217,163

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 7.49 **2012 NF PE RVU:** 6.22
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.27 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70496 **Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 127,977

2007 Work RVU: 1.75 **2012 Work RVU:** 1.75
2007 NF PE RVU: 12.43 **2012 NF PE RVU:** 14.65
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from Screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

70498 **Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 158,990

2007 Work RVU: 1.75 **2012 Work RVU:** 1.75
2007 NF PE RVU: 12.45 **2012 NF PE RVU:** 15.09
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from Screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

70551 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 806,882

2007 Work RVU: 1.48 **2012 Work RVU:** 1.48
2007 NF PE RVU: 12.2 **2012 NF PE RVU:** 12.68
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70553 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** AUR, ACR, ASNR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 956,496

2007 Work RVU: 2.36 **2012 Work RVU:** 2.36
2007 NF PE RVU: 23.53 **2012 NF PE RVU:** 16.83
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

71010 **Radiologic examination, chest; single view, frontal**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 18,956,128

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.5 **2012 NF PE RVU:** 0.50
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.18

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

71020 **Radiologic examination, chest, 2 views, frontal and lateral;**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 13,329,285

2007 Work RVU: 0.22 **2012 Work RVU:** 0.22
2007 NF PE RVU: 0.66 **2012 NF PE RVU:** 0.67
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

71090 **Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation**

Global: XXX **Issue:** Insertion/Removal of Pacemeaker or Pacing Cardioverter-Defibrillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 231,390

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71250 **Computed tomography, thorax; without contrast material**

Global: XXX **Issue:** CT Thorax **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,371,357

2007 Work RVU: 1.16 **2012 Work RVU:** 1.02
2007 NF PE RVU: 6.24 **2012 NF PE RVU:** 5.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71275 **Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing / MPC List **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 592,398

2007 Work RVU: 1.92 **2012 Work RVU:** 1.92
2007 NF PE RVU: 12.53 **2012 NF PE RVU:** 11.08
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review September 2013. CPT Assistant article published. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

Status Report: CMS Requests and Relativity Assessment Issues

72040 **Radiologic examination, spine, cervical; 2 or 3 views** **Global:** XXX **Issue:** X-ray of Cervical Spine **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2010 **2010 Medicare Utilization Data:** 571,186

2007 Work RVU: 0.22 **2012 Work RVU:** 0.22
2007 NF PE RVU: 0.69 **2012 NF PE RVU:** 0.93
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.22 **CPT Action (if applicable):** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72050 **Radiologic examination, spine, cervical; minimum of 4 views** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** **2010 Medicare Utilization Data:** 454,961

2007 Work RVU: 0.31 **2012 Work RVU:** 0.31
2007 NF PE RVU: 1 **2012 NF PE RVU:** 1.25
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.31 **CPT Action (if applicable):** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72052 **Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** **2010 Medicare Utilization Data:** 96,026

2007 Work RVU: 0.36 **2012 Work RVU:** 0.36
2007 NF PE RVU: 1.27 **2012 NF PE RVU:** 1.65
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.36 **CPT Action (if applicable):** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72100 **Radiologic examination, spine, lumbosacral; 2 or 3 views** **Global:** XXX **Issue:** Radiologic Examination - Spine **Screen:** Harvard Valued - Utilization over 100,000 / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,824,867

2007 Work RVU: 0.22 **2012 Work RVU:** 0.22
2007 NF PE RVU: 0.75 **2012 NF PE RVU:** 0.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.22 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72110 **Radiologic examination, spine, lumbosacral; minimum of 4 views** **Global:** XXX **Issue:** Radiologic Examination – Spine **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 912,604

2007 Work RVU: 0.31 **2012 Work RVU:** 0.31
2007 NF PE RVU: 1.03 **2012 NF PE RVU:** 1.16
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.31 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72114 **Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views** **Global:** XXX **Issue:** Radiologic Examination – Spine **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 98,452

2007 Work RVU: 0.36 **2012 Work RVU:** 0.32
2007 NF PE RVU: 1.36 **2012 NF PE RVU:** 1.61
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.32 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72120 **Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views** **Global:** XXX **Issue:** Radiologic Examination – Spine **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 24,366

2007 Work RVU: 0.22 **2012 Work RVU:** 0.22
2007 NF PE RVU: 0.98 **2012 NF PE RVU:** 1.06
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.22 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72125 **Computed tomography, cervical spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 22 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 662,933

2007 Work RVU: 1.16 **2012 Work RVU:** 1.07
2007 NF PE RVU: 6.24 **2012 NF PE RVU:** 5.91
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72126 **Computed tomography, cervical spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 19,201

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2012 NF PE RVU:** 7.31
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

72127 **Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 1,908

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 9.3 **2012 NF PE RVU:** 8.98
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72128 **Computed tomography, thoracic spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 22 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 94,885

2007 Work RVU: 1.16 **2012 Work RVU:** 1
2007 NF PE RVU: 6.24 **2012 NF PE RVU:** 5.87
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72129 **Computed tomography, thoracic spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 11,365

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2012 NF PE RVU:** 7.31
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

72130 **Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 1,107

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 9.29 **2012 NF PE RVU:** 9.06
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

72131 **Computed tomography, lumbar spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 22 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 323,319

2007 Work RVU: 1.16 **2012 Work RVU:** 1
2007 NF PE RVU: 6.24 **2012 NF PE RVU:** 5.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.16 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72132 **Computed tomography, lumbar spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 54,055

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2012 NF PE RVU:** 7.29
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

72133 **Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 4,156

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 9.34 **2012 NF PE RVU:** 9.04
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

72141 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material** **Global:** XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 486,590

2007 Work RVU: 1.60 **2012 Work RVU:** 1.6
2007 NF PE RVU: 11.76 **2012 NF PE RVU:** 11.05
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72148 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** AAOS, AUR, ACR, NASS, ASNR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 1,127,051

2007 Work RVU: 1.48 **2012 Work RVU:** 1.48
2007 NF PE RVU: 12.66 **2012 NF PE RVU:** 11.10
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Survey for work and PE for April 2013 RUC meeting.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

72170 **Radiologic examination, pelvis; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exam of Pelvis **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 25 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,721,410

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.56 **2012 NF PE RVU:** 0.59
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 0.17

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

72191 **Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth / CMS Fastest Growing / Codes Reported Together 75% or More / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 49 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 113,124

2007 Work RVU: 1.81 **2012 Work RVU:** 1.81
2007 NF PE RVU: 12.15 **2012 NF PE RVU:** 11.57
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 1.81 and PE inputs

CPT Action (if applicable): October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72192 **Computed tomography, pelvis; without contrast material**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,925,530

2007 Work RVU: 1.09 **2012 Work RVU:** 1.09
2007 NF PE RVU: 6.12 **2012 NF PE RVU:** 5.54
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.09 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72193 **Computed tomography, pelvis; with contrast material(s)**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 2,369,940

2007 Work RVU: 1.16 **2012 Work RVU:** 1.16
2007 NF PE RVU: 7.2 **2012 NF PE RVU:** 6.90
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.16 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72194 **Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2010 Medicare Utilization Data:** 442,330

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 9.06 **2012 NF PE RVU:** 9.14
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.22 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72275 **Epidurography, radiological supervision and interpretation**

Global: XXX **Issue:** Epidurography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 87,042

2007 Work RVU: 0.76 **2012 Work RVU:** 0.76
2007 NF PE RVU: 2.15 **2012 NF PE RVU:** 2.73
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.76, CPT Assistant article published.

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009 and Q&A

73030 **Radiologic examination, shoulder; complete, minimum of 2 views**

Global: XXX **Issue:** X-Ray Exam of Shoulder **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 26 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2010 **2010 Medicare Utilization Data:** 2,172,106

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.61 **2012 NF PE RVU:** 0.71
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.18

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73080 **Radiologic examination, elbow; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 39 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 292,588

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.66 **2012 NF PE RVU:** 0.83
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.17

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73110 **Radiologic examination, wrist; complete, minimum of 3 views**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 876,970

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.63 **2012 NF PE RVU:** 0.93
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73130 **Radiologic examination, hand; minimum of 3 views** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 916,888

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.6 **2012 NF PE RVU:** 0.78
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

73200 **Computed tomography, upper extremity; without contrast material** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 23 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 69,732

2007 Work RVU: 1.09 **2012 Work RVU:** 1
2007 NF PE RVU: 5.5 **2012 NF PE RVU:** 5.74
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.09 **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

73201 **Computed tomography, upper extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 9,665

2007 Work RVU: 1.16 **2012 Work RVU:** 1.16
2007 NF PE RVU: 6.58 **2012 NF PE RVU:** 7.12
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Remove from Screen

73202 **Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 1,638

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 8.38 **2012 NF PE RVU:** 9.43
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

73218 **Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 29,137

2007 Work RVU: 1.35 **2012 Work RVU:** 1.35
2007 NF PE RVU: 12.24 **2012 NF PE RVU:** 12.61
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review September 2013. CPT Assistant published.

CPT Action (if applicable):
Result:
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2011

73221 **Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 411,261

2007 Work RVU: 1.35 **2012 Work RVU:** 1.35
2007 NF PE RVU: 11.98 **2012 NF PE RVU:** 11.92
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.35

CPT Action (if applicable):
Result: Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73500 **Radiologic examination, hip, unilateral; 1 view**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 504,197

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.52 **2012 NF PE RVU:** 0.61
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT

CPT Action (if applicable):
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73510 **Radiologic examination, hip, unilateral; complete, minimum of 2 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 2,445,177

2007 Work RVU: 0.21 **2012 Work RVU:** 0.21
2007 NF PE RVU: 0.67 **2012 NF PE RVU:** 0.93
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.21 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73542 **Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation**

Global: XXX **Issue:** Sacroiliac Joint Arthrography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 25,145

2007 Work RVU: 0.59 **2012 Work RVU:**
2007 NF PE RVU: 1.98 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT

73550 **Radiologic examination, femur, 2 views**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 531,186

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.61 **2012 NF PE RVU:** 0.65
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73560 **Radiologic examination, knee; 1 or 2 views** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 2,120,952

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.58 **2012 NF PE RVU:** 0.73
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

73562 **Radiologic examination, knee; 3 views** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,813,102

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.65 **2012 NF PE RVU:** 0.90
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

73564 **Radiologic examination, knee; complete, 4 or more views** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,064,370

2007 Work RVU: 0.22 **2012 Work RVU:** 0.22
2007 NF PE RVU: 0.73 **2012 NF PE RVU:** 1.05
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

73580 **Radiologic examination, knee, arthrography, radiological supervision and interpretation** **Global:** XXX **Issue:** Contrast X-Ray of Knee Joint **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 17,989

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 2.67 **2012 NF PE RVU:** 3.47
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant Article published June 2012. **CPT Action (if applicable):**
Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73610 **Radiologic examination, ankle; complete, minimum of 3 views** **Global:** XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,155,261

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.61 **2012 NF PE RVU:** 0.81
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.17 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73620 **Radiologic examination, foot; 2 views** **Global:** XXX **Issue:** X-Ray Exam of Foot **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 27 **Specialty Developing Recommendation:** ACR, AAOS, APMA **First Identified:** October 2010 **2010 Medicare Utilization Data:** 838,983

2007 Work RVU: 0.16 **2012 Work RVU:** 0.16
2007 NF PE RVU: 0.54 **2012 NF PE RVU:** 0.64
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.16 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73630 **Radiologic examination, foot; complete, minimum of 3 views** **Global:** XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 2,164,170

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.6 **2012 NF PE RVU:** 0.76
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.17 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73700 **Computed tomography, lower extremity; without contrast material** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 183,803

2007 Work RVU: 1.09 **2012 Work RVU:** 1
2007 NF PE RVU: 5.5 **2012 NF PE RVU:** 5.75
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.09 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73701 **Computed tomography, lower extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 37,207

2007 Work RVU: 1.16 **2012 Work RVU:** 1.16
2007 NF PE RVU: 6.6 **2012 NF PE RVU:** 7.21
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

73702 **Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2010 Medicare Utilization Data:** 4,147

2007 Work RVU: 1.22 **2012 Work RVU:** 1.22
2007 NF PE RVU: 8.4 **2012 NF PE RVU:** 9.43
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

73706 **Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 16,643

2007 Work RVU: 1.90 **2012 Work RVU:** 1.9
2007 NF PE RVU: 11.61 **2012 NF PE RVU:** 11.22
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

73721 **Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material** **Global:** XXX **Issue:** MRI of Lower Extremity Joint **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2010 Medicare Utilization Data:** 599,170

2007 Work RVU: 1.35 **2012 Work RVU:** 1.35
2007 NF PE RVU: 12.05 **2012 NF PE RVU:** 12.22
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.35 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74000 **Radiologic examination, abdomen; single anteroposterior view** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,941,697

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.55 **2012 NF PE RVU:** 0.54
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74150 **Computed tomography, abdomen; without contrast material** **Global:** XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,936,054

2007 Work RVU: 1.19 **2012 Work RVU:** 1.19
2007 NF PE RVU: 5.97 **2012 NF PE RVU:** 5.56
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.35 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74160 **Computed tomography, abdomen; with contrast material(s)** **Global:** XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / MPC List / CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 2,236,657

2007 Work RVU: 1.27 **2012 Work RVU:** 1.27
2007 NF PE RVU: 7.53 **2012 NF PE RVU:** 7.95
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.42 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74170 **Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 859,320

2007 Work RVU: 1.40 **2012 Work RVU:** 1.4
2007 NF PE RVU: 9.6 **2012 NF PE RVU:** 10.83
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.40 **CPT Action (if applicable):** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74174 **Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography-Abdomen and Pelvis **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 10 **Specialty Developing Recommendation:** ACR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2.2
2007 NF PE RVU: **2012 NF PE RVU:** 14.17
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 2.20 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74175 **Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 49 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 168,170

2007 Work RVU: 1.90 **2012 Work RVU:** 1.9
2007 NF PE RVU: 12.39 **2012 NF PE RVU:** 12.33
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.90 and PE inputs **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74176 **Computed tomography, abdomen and pelvis; without contrast material** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 16 **Specialty Developing Recommendation:** ACR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.74
2007 NF PE RVU: **2012 NF PE RVU:** 4.80
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.74 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74177 **Computed tomography, abdomen and pelvis; with contrast material(s)** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 16 **Specialty Developing Recommendation:** ACR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.82
2007 NF PE RVU: **2012 NF PE RVU:** 8.58
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.82 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74178 **Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 16 **Specialty Developing Recommendation:** ACR **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2.01
2007 NF PE RVU: **2012 NF PE RVU:** 11.21
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 2.01 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74247 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB** **Global:** XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 33,487

2007 Work RVU: 0.69 **2012 Work RVU:** 0.69
2007 NF PE RVU: 2.18 **2012 NF PE RVU:** 3.54
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.69 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74280 **Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon**

Global: XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 30,104

2007 Work RVU: 0.99 **2012 Work RVU:** 0.99
2007 NF PE RVU: 3.07 **2012 NF PE RVU:** 5.43
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.99 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74400 **Urography (pyelography), intravenous, with or without KUB, with or without tomography**

Global: XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2010 Medicare Utilization Data:** 29,266

2007 Work RVU: 0.49 **2012 Work RVU:** 0.49
2007 NF PE RVU: 2 **2012 NF PE RVU:** 2.84
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.49 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

75635 **Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 10 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 86,448

2007 Work RVU: 2.40 **2012 Work RVU:** 2.4
2007 NF PE RVU: 15.56 **2012 NF PE RVU:** 12.22
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from Screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75650 **Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation**

Global: XXX **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 32,018

2007 Work RVU: 1.49 **2012 Work RVU:** 1.49
2007 NF PE RVU: 10.66 **2012 NF PE RVU:** 4.49
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75671 **Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation**

Global: XXX **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 33,250

2007 Work RVU: 1.66 **2012 Work RVU:** 1.66
2007 NF PE RVU: 11.08 **2012 NF PE RVU:** 6.37
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75680 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: XXX **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 36,443

2007 Work RVU: 1.66 **2012 Work RVU:** 1.66
2007 NF PE RVU: 10.96 **2012 NF PE RVU:** 5.69
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75722 **Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation**

Global: XXX **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 9,347

2007 Work RVU: 1.14 **2012 Work RVU:**
2007 NF PE RVU: 10.7 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75724 **Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation**

Global: XXX **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 33,533

2007 Work RVU: 1.49 **2012 Work RVU:**
2007 NF PE RVU: 11.15 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75790 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.84 **2012 Work RVU:**
2007 NF PE RVU: 2.2 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75791 **Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation**

Global: XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** **2010 Medicare Utilization Data:** 26,526

2007 Work RVU: **2012 Work RVU:** 1.71
2007 NF PE RVU: **2012 NF PE RVU:** 8.18
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.71 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

75885 **Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2010 Medicare Utilization Data:** 320

2007 Work RVU: 1.44 **2012 Work RVU:** 1.44
2007 NF PE RVU: 10.54 **2012 NF PE RVU:** 4.31
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75887 **Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2010 Medicare Utilization Data:** 310

2007 Work RVU: 1.44 **2012 Work RVU:** 1.44
2007 NF PE RVU: 10.6 **2012 NF PE RVU:** 4.34
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75894 **Transcatheter therapy, embolization, any method, radiological supervision and interpretation**

Global: XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 33,134

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: NA **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** October 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

75896 **Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation**

Global: XXX **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 18,190

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: NA **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Carrier Price **CPT Action (if applicable):** October 2011 **Result:** Carrier Price
Referred to CPT Asst ☐ **Published in CPT Asst:**

75898 **Transurethral destruction of prostate tissue; by microwave thermotherapy**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price **CPT Action (if applicable):** October 2011 **Result:** Carrier Price
Referred to CPT Asst ☐ **Published in CPT Asst:**

75940 **Percutaneous placement of IVC filter, radiological supervision and interpretation**

Global: XXX **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 61,120

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75960 **Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel**

Global: XXX **Issue:** Endovascular Revascularization **Screen:** High Volume Growth / Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 142,149

2007 Work RVU: 0.00 **2012 Work RVU:** 0.82
2007 NF PE RVU: NA **2012 NF PE RVU:** 3.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2013 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

75961 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation**

Global: XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 4,343

2007 Work RVU: 4.24 **2012 Work RVU:** 4.24
2007 NF PE RVU: 9.99 **2012 NF PE RVU:** 5.63
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** June 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75962 **Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation**

Global: XXX **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 133,823

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 12.8 **2012 NF PE RVU:** 4.69
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75964 **Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2010 Medicare Utilization Data:** 43,837

2007 Work RVU: 0.36 **2012 Work RVU:** 0.36
2007 NF PE RVU: 6.96 **2012 NF PE RVU:** 3.00
2007 Fac PE RVU: 6.96 **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** February 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

75992 **Deleted from CPT**

Global: XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 27,603

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75993 **Deleted from CPT**

Global: ZZZ **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 9,724

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75994 **Revised to Category III**

Global: XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 277

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Remove from screen **CPT Action (if applicable):** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75995 **Revised to Category III** **Global:** XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 43

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Remove from screen **CPT Action (if applicable):** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

75996 **Revised to Category III** **Global:** ZZZ **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 12

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Remove from screen **CPT Action (if applicable):** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

76000 **Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)** **Global:** XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 136,840

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 1.68 **2012 NF PE RVU:** 1.74
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Maintain **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76100 **Radiologic examination, single plane body section (eg, tomography), other than with urography** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2010 Medicare Utilization Data:** 5,315

2007 Work RVU: 0.58 **2012 Work RVU:** 0.58
2007 NF PE RVU: 1.93 **2012 NF PE RVU:** 2.71
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76101 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral**

Global: XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2010 Medicare Utilization Data:** 583

2007 Work RVU: 0.58 **2012 Work RVU:** 0.58
2007 NF PE RVU: 2.5 **2012 NF PE RVU:** 4.25
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

76102 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral**

Global: XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2010 Medicare Utilization Data:** 702

2007 Work RVU: 0.58 **2012 Work RVU:** 0.58
2007 NF PE RVU: 3.35 **2012 NF PE RVU:** 5.95
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

76513 **Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy**

Global: XXX **Issue:** Ophthalmic Ultrasound **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** February 2008 **2010 Medicare Utilization Data:** 19,128

2007 Work RVU: 0.66 **2012 Work RVU:** 0.66
2007 NF PE RVU: 1.75 **2012 NF PE RVU:** 2.02
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant Article and 0.66. **CPT Action (if applicable):** May 2008 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** SS submitted articl

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76536 **Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation**

Global: XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2010 Medicare Utilization Data:** 592,261

2007 Work RVU: 0.56 **2012 Work RVU:** 0.56
2007 NF PE RVU: 1.83 **2012 NF PE RVU:** 3.02
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.56 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76645 **Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 790,811

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 1.41 **2012 NF PE RVU:** 2.33
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to Research Subcommittee **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

76700 **Ultrasound, abdominal, real time with image documentation; complete**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,040,905

2007 Work RVU: 0.81 **2012 Work RVU:** 0.81
2007 NF PE RVU: 2.39 **2012 NF PE RVU:** 3.36
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76705 **Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 957,502

2007 Work RVU: 0.59 **2012 Work RVU:** 0.59
2007 NF PE RVU: 1.77 **2012 NF PE RVU:** 2.60
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to Research Subcommittee **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

76770 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 1,087,261

2007 Work RVU: 0.74 **2012 Work RVU:** 0.74
2007 NF PE RVU: 2.36 **2012 NF PE RVU:** 3.21
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to Research Subcommittee **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76775 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 716,487

2007 Work RVU: 0.58 **2012 Work RVU:** 0.58
2007 NF PE RVU: 1.81 **2012 NF PE RVU:** 2.68
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to Research Subcommittee **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

76830 **Ultrasound, transvaginal**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 457,192

2007 Work RVU: 0.69 **2012 Work RVU:** 0.69
2007 NF PE RVU: 1.97 **2012 NF PE RVU:** 3.06
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.69 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76856 **Ultrasound, pelvic (nonobstetric), real time with image documentation; complete**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 545,291

2007 Work RVU: 0.69 **2012 Work RVU:** 0.69
2007 NF PE RVU: 1.99 **2012 NF PE RVU:** 3.02
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to Research Subcommittee **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

76872 **Ultrasound, transrectal;**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 261,922

2007 Work RVU: 0.69 **2012 Work RVU:** 0.69
2007 NF PE RVU: 2.52 **2012 NF PE RVU:** 3.35
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.69 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76880 **Deleted from CPT** **Global:** XXX **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 26 **Specialty Developing Recommendation:** APMA, ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 262,901

2007 Work RVU: 0.59 **2012 Work RVU:**
2007 NF PE RVU: 1.97 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76881 **Ultrasound, extremity, nonvascular, real-time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 17 **Specialty Developing Recommendation:** AAPMR, APMA, ACR **First Identified:** April 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.63
2007 NF PE RVU: **2012 NF PE RVU:** 2.94
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: Develop CPT Assistant article. 0.72 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** SS to develop CCP

76882 **Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific** **Global:** XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2010 **Tab** 17 **Specialty Developing Recommendation:** AAPMR, APMA, ACR **First Identified:** April 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.49
2007 NF PE RVU: **2012 NF PE RVU:** 0.48
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: Develop CPT Assistant article. 0.50 **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** SS to develop CCP

Status Report: CMS Requests and Relativity Assessment Issues

76942 **Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACR, AACE, AAPM, AAOS, ASA, AUA, ACRh, ACRO, SIR, TES, ASIPP **First Identified:** April 2011 **2010 Medicare Utilization Data:** 1,261,256

2007 Work RVU: 0.67 **2012 Work RVU:** 0.67
2007 NF PE RVU: 3.43 **2012 NF PE RVU:** 5.35
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Action Plan

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

76950 **Ultrasonic guidance for placement of radiation therapy fields**

Global: XXX **Issue:** IMRT with Ultrasound Guidance **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** February 2010 **2010 Medicare Utilization Data:** 68,736

2007 Work RVU: 0.58 **2012 Work RVU:** 0.58
2007 NF PE RVU: 1.43 **2012 NF PE RVU:** 1.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

76970 **Ultrasound study follow-up (specify)**

Global: XXX **Issue:** IMRT with Ultrasound Guidance **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACS, ACR, AACE **First Identified:** February 2008 **2010 Medicare Utilization Data:** 13,377

2007 Work RVU: 0.40 **2012 Work RVU:** 0.4
2007 NF PE RVU: 1.41 **2012 NF PE RVU:** 2.58
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

77001 **Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 21 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 464,725

2007 Work RVU: 0.38 **2012 Work RVU:** 0.38
2007 NF PE RVU: 1.73 **2012 NF PE RVU:** 3.09
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review Action Plan at RAW **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

77002 **Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 21 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 220,148

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 1.4 **2012 NF PE RVU:** 1.72
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review Action Plan at RAW **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

77003 **Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)**

Global: XXX **Issue:** Fluroscopic Guidance for Spine Injection **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 21 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, NASS, SIR **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,890,663

2007 Work RVU: 0.60 **2012 Work RVU:** 0.6
2007 NF PE RVU: 1.28 **2012 NF PE RVU:** 1.26
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.60 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77011 **Computed tomography guidance for stereotactic localization** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 15 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** **2010 Medicare Utilization Data:** 5,807

2007 Work RVU: 1.21 **2012 Work RVU:** 1.21
2007 NF PE RVU: 11.38 **2012 NF PE RVU:** 9.35
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77014 **Computed tomography guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ASTRO, ACR **First Identified:** October 2010 **2010 Medicare Utilization Data:** 783,285

2007 Work RVU: 0.85 **2012 Work RVU:** 0.85
2007 NF PE RVU: 3.53 **2012 NF PE RVU:** 3.32
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

77052 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 4,790,060

2007 Work RVU: 0.06 **2012 Work RVU:** 0.06
2007 NF PE RVU: 0.38 **2012 NF PE RVU:** 0.24
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77079 **Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: XXX **Issue:** CT Bone Density Study **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACR, AAFP, ACP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 1,318

2007 Work RVU: 0.22 **2012 Work RVU:**
2007 NF PE RVU: 2.45 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77080 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)**

Global: XXX **Issue:** Dual-energy X-ray Absorptiometry **Screen:** CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 23 **Specialty Developing Recommendation:** AACE, ACR, ACRh, TES **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,479,421

2007 Work RVU: 0.20 **2012 Work RVU:** 0.23
2007 NF PE RVU: 2.59 **2012 NF PE RVU:** 2.50
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.20 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77082 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment**

Global: XXX **Issue:** Dual-energy X-ray Absorptiometry **Screen:** CMS Request - NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 23 **Specialty Developing Recommendation:** AACE, ACR, ACRh, TES **First Identified:** September 2011 **2010 Medicare Utilization Data:** 156,183

2007 Work RVU: 0.17 **2012 Work RVU:** 0.13
2007 NF PE RVU: 0.71 **2012 NF PE RVU:** 0.63
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.17 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77083 **Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites**

Global: XXX **Issue:** Radiographic Absorptiometry **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACR, ACP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 1,112

2007 Work RVU: 0.20 **2012 Work RVU:**
2007 NF PE RVU: 0.71 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77280 **Therapeutic radiology simulation-aided field setting; simple**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 25 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2011 **2010 Medicare Utilization Data:** 273,963

2007 Work RVU: 0.70 **2012 Work RVU:** 0.7
2007 NF PE RVU: 3.89 **2012 NF PE RVU:** 4.77
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

77285 **Therapeutic radiology simulation-aided field setting; intermediate**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 25 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2010 Medicare Utilization Data:** 4,634

2007 Work RVU: 1.05 **2012 Work RVU:** 1.05
2007 NF PE RVU: 6.45 **2012 NF PE RVU:** 8.62
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

77290 **Therapeutic radiology simulation-aided field setting; complex**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** MPC List / Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 25 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2010 Medicare Utilization Data:** 334,547

2007 Work RVU: 1.56 **2012 Work RVU:** 1.56
2007 NF PE RVU: 8.63 **2012 NF PE RVU:** 14.11
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77295 **Therapeutic radiology simulation-aided field setting; 3-dimensional**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 25 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2010 Medicare Utilization Data:** 138,880

2007 Work RVU: 4.56 **2012 Work RVU:** 4.56
2007 NF PE RVU: 23.92 **2012 NF PE RVU:** 9.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

77300 **Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,706,082

2007 Work RVU: 0.62 **2012 Work RVU:** 0.62
2007 NF PE RVU: 1.45 **2012 NF PE RVU:** 1.33
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77301 **Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications**

Global: XXX **Issue:** Radiotherapy Dose Plan IMRT **Screen:** CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 45 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2010 Medicare Utilization Data:** 90,639

2007 Work RVU: 7.99 **2012 Work RVU:** 7.99
2007 NF PE RVU: 37.25 **2012 NF PE RVU:** 49.69
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 7.99. CPT Assistant article published. **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009

Status Report: CMS Requests and Relativity Assessment Issues

77334 **Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 852,282

2007 Work RVU: 1.24 **2012 Work RVU:** 1.24
2007 NF PE RVU: 3.43 **2012 NF PE RVU:** 3.06
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77371 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based**

Global: XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 30 **Specialty Developing Recommendation:** ASTRO **First Identified:** NA **2010 Medicare Utilization Data:** 36

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 30.25 **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.00

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77418 **Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session**

Global: XXX **Issue:** IMRT with Stereotopic X-ray Guidance and IMRT with Ultrasound Guidance **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** ASBS, ASTRO, ACRO **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,366,399

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 16.8 **2012 NF PE RVU:** 13.97
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs. CPT Assistant article published. **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009 and Q&A

Status Report: CMS Requests and Relativity Assessment Issues

77421 **Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: XXX **Issue:** IMRT with Stereotopic X-ray Guidance **Screen:** Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,140,462

2007 Work RVU: 0.39 **2012 Work RVU:** 0.39
2007 NF PE RVU: 3.11 **2012 NF PE RVU:** 2.13
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT. New PE inputs Feb 2010.

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

77427 **Radiation treatment management, 5 treatments**

Global: XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 27 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2007 **2010 Medicare Utilization Data:** 1,194,406

2007 Work RVU: 3.70 **2012 Work RVU:** 3.37
2007 NF PE RVU: 1.15 **2012 NF PE RVU:** 1.56
2007 Fac PE RVU: 1.15 **2012 Fac PE RVU:** 1.56

RUC Recommendation: 3.45

CPT Action (if applicable): June 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77781 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.21 **2012 Work RVU:**
2007 NF PE RVU: 16.73 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2008
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

77782 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 2.04 **2012 Work RVU:**
2007 NF PE RVU: 18.94 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77784 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 5.15 **2012 Work RVU:**
2007 NF PE RVU: 28.04 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77785 **Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

Global: XXX **Issue:** High Dose Rate Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing/CMS Request - Practice Expense **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2010 Medicare Utilization Data:** 26,938

2007 Work RVU: **2012 Work RVU:** 1.42
2007 NF PE RVU: **2012 NF PE RVU:** 5.34
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.42 and new PE inputs **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77786 **Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels** **Global:** XXX **Issue:** High Dose Rate Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing/CMS Request - Practice Expense **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2010 Medicare Utilization Data:** 29,904

2007 Work RVU: **2012 Work RVU:** 3.25
2007 NF PE RVU: **2012 NF PE RVU:** 13.04
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 3.25 and new PE inputs **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77787 **Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels** **Global:** XXX **Issue:** High Dose Rate Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing/CMS Request - Practice Expense **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2010 Medicare Utilization Data:** 6,907

2007 Work RVU: **2012 Work RVU:** 4.89
2007 NF PE RVU: **2012 NF PE RVU:** 22.12
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 4.89 and new PE inputs **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78000 **Thyroid uptake; single determination** **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:** 1,402

2007 Work RVU: 0.19 **2012 Work RVU:** 0.19
2007 NF PE RVU: 1.21 **2012 NF PE RVU:** 1.98
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78001 **Thyroid uptake; multiple determinations** **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:** 1,130

2007 Work RVU: 0.26 **2012 Work RVU:** 0.26
2007 NF PE RVU: 1.59 **2012 NF PE RVU:** 2.49
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78003 **Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)** **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:** 19

2007 Work RVU: 0.33 **2012 Work RVU:** 0.33
2007 NF PE RVU: 1.26 **2012 NF PE RVU:** 2.10
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78006 **Thyroid imaging, with uptake; single determination** **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:** 20,307

2007 Work RVU: 0.49 **2012 Work RVU:** 0.49
2007 NF PE RVU: 3.38 **2012 NF PE RVU:** 6.69
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78007 **Thyroid imaging, with uptake; multiple determinations** **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2010 Medicare Utilization Data:** 29,384

2007 Work RVU: 0.50 **2012 Work RVU:** 0.5
2007 NF PE RVU: 2.76 **2012 NF PE RVU:** 6.32
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78010 **Thyroid imaging; only**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:** 6,404

2007 Work RVU: 0.39 **2012 Work RVU:** 0.39
2007 NF PE RVU: 2.45 **2012 NF PE RVU:** 4.59
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78011 **Thyroid imaging; with vascular flow**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:** 188

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 2.99 **2012 NF PE RVU:** 4.86
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78012 **Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.19 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78013 **Thyroid imaging (including vascular flow, when performed);**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.37 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78014 **Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.50 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78070 **Parathyroid planar imaging (including subtraction, when performed);**

Global: **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 23 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.80 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78071 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)**

Global: **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 23 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.20 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78072 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization**

Global: **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 23 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.60 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78223 **Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function**

Global: XXX **Issue:** Hepatobiliary Ductal System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2009 **2010 Medicare Utilization Data:** 179,697

2007 Work RVU: 0.84 **2012 Work RVU:**
2007 NF PE RVU: 4.95 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78226 **Hepatobiliary system imaging, including gallbladder when present;**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.74
2007 NF PE RVU: **2012 NF PE RVU:** 8.84
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.74 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78227 **Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.9
2007 NF PE RVU: **2012 NF PE RVU:** 12.23
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.90 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78278 **Acute gastrointestinal blood loss imaging**

Global: XXX **Issue:** Acute GI Blood Loss Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 34 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** April 2011 **2010 Medicare Utilization Data:** 38,195

2007 Work RVU: 0.99 **2012 Work RVU:** 0.99
2007 NF PE RVU: 5.92 **2012 NF PE RVU:** 9.38
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.99 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78451 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2010 Medicare Utilization Data:** 71,735

2007 Work RVU: **2012 Work RVU:** 1.38
2007 NF PE RVU: **2012 NF PE RVU:** 9.14
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.40 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78452 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2010 Medicare Utilization Data:** 2,547,580

2007 Work RVU: **2012 Work RVU:** 1.62
2007 NF PE RVU: **2012 NF PE RVU:** 13.08
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.75 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78453 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2010 Medicare Utilization Data:** 3,586

2007 Work RVU: **2012 Work RVU:** 1
2007 NF PE RVU: **2012 NF PE RVU:** 8.06
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.00 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78454 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2010 Medicare Utilization Data:** 18,718

2007 Work RVU: **2012 Work RVU:** 1.34
2007 NF PE RVU: **2012 NF PE RVU:** 11.63
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.34 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78460 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: 0.86 **2012 Work RVU:**
2007 NF PE RVU: 3.1 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78461 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: 1.23 **2012 Work RVU:**
2007 NF PE RVU: 4.81 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78464 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: 1.09 **2012 Work RVU:**
2007 NF PE RVU: 7.03 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78465 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.46 **2012 Work RVU:**
2007 NF PE RVU: 12.08 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78472 **Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing**

Global: XXX **Issue:** Cardiac Blood Pool Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 35 **Specialty Developing Recommendation:** ACC, ACR, SNM, ACNM **First Identified:** April 2011 **2010 Medicare Utilization Data:** 51,453

2007 Work RVU: 0.98 **2012 Work RVU:** 0.98
2007 NF PE RVU: 5.87 **2012 NF PE RVU:** 6.24
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.98 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78478 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.50 **2012 Work RVU:**
2007 NF PE RVU: 1.54 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78480 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.30 **2012 Work RVU:**
2007 NF PE RVU: 1.51 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78579 **Pulmonary ventilation imaging (eg, aerosol or gas)** **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.49
2007 NF PE RVU: **2012 NF PE RVU:** 4.59
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.49 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78580 **Pulmonary perfusion imaging (eg, particulate)** **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 28,385

2007 Work RVU: 0.74 **2012 Work RVU:** 0.74
2007 NF PE RVU: 3.97 **2012 NF PE RVU:** 5.82
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.74 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

78582 **Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging** **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.07
2007 NF PE RVU: **2012 NF PE RVU:** 8.31
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.07 **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78584 **Pulmonary perfusion imaging, particulate, with ventilation; single breath** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 25,571

2007 Work RVU: 0.99 **2012 Work RVU:**
2007 NF PE RVU: 3.34 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78585 **Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath**

Global: XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 117,066

2007 Work RVU: 1.09 **2012 Work RVU:**
2007 NF PE RVU: 6.53 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78586 **Pulmonary ventilation imaging, aerosol; single projection**

Global: XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 699

2007 Work RVU: 0.40 **2012 Work RVU:**
2007 NF PE RVU: 3.02 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78587 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,402

2007 Work RVU: 0.49 **2012 Work RVU:**
2007 NF PE RVU: 3.51 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78588 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 96,017

2007 Work RVU: 1.09 **2012 Work RVU:**
2007 NF PE RVU: 4.7 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78591 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 324

2007 Work RVU: 0.40 **2012 Work RVU:**
2007 NF PE RVU: 3.21 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78593 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 3,801

2007 Work RVU: 0.49 **2012 Work RVU:**
2007 NF PE RVU: 3.84 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78594 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,197

2007 Work RVU: 0.53 **2012 Work RVU:**
2007 NF PE RVU: 5.12 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78596 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 7,700

2007 Work RVU: 1.27 **2012 Work RVU:**
2007 NF PE RVU: 7.7 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78597 **Quantitative differential pulmonary perfusion, including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.75
2007 NF PE RVU: **2012 NF PE RVU:** 4.99
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.75 **CPT Action (if applicable):** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78598 **Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.85
2007 NF PE RVU: **2012 NF PE RVU:** 7.97
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.85 **CPT Action (if applicable):** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78815 **Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2010 **2010 Medicare Utilization Data:** 495,289

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0 **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: 0 **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

79101 **Radiopharmaceutical therapy, by intravenous administration**

Global: XXX **Issue:** Radiopharmaceutical Therapy **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 2,528

2007 Work RVU: 1.96 **2012 Work RVU:** 1.96
2007 NF PE RVU: 2.98 **2012 NF PE RVU:** 2.52
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Article published Feb 2012 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2012

88104 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 122,243

2007 Work RVU: 0.56 **2012 Work RVU:** 0.56
2007 NF PE RVU: 0.93 **2012 NF PE RVU:** 1.41
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.56 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88106 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 7,603

2007 Work RVU: 0.56 **2012 Work RVU:** 0.37
2007 NF PE RVU: 1.39 **2012 NF PE RVU:** 1.75
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.56 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88107 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 5,592

2007 Work RVU: 0.76 **2012 Work RVU:**
2007 NF PE RVU: 1.66 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88108 **Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 321,955

2007 Work RVU: 0.56 **2012 Work RVU:** 0.44
2007 NF PE RVU: 1.27 **2012 NF PE RVU:** 1.62
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.56 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88112 **Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 937,311

2007 Work RVU: 1.18 **2012 Work RVU:** 1.18
2007 NF PE RVU: 1.85 **2012 NF PE RVU:** 1.78
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

88300 **Level I - Surgical pathology, gross examination only**

Global: XXX **Issue:** Pathology Consultations **Screen:** Top 9 Harvard / Low Value-Billed in Multiple Units / CMS Request NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2010 Medicare Utilization Data:** 211,051

2007 Work RVU: 0.08 **2012 Work RVU:** 0.08
2007 NF PE RVU: 0.49 **2012 NF PE RVU:** 0.73
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.08 and new PE inputs **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88302 **Level II - Surgical pathology, gross and microscopic examination Appendix, incidental, Fallopian tube, sterilization, Fingers/toes, amputation, traumatic, Foreskin, newborn, Hernia sac, any location, Hydrocele sac, Nerve, Skin, plastic repair, Sympathetic ganglion, Testis, castration Vaginal mucosa, incidental, Vas deferens, sterilization**

Global: XXX **Issue:** Pathology Consultations **Screen:** Top 9 Harvard / CMS Request NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2010 Medicare Utilization Data:** 105,697

2007 Work RVU: 0.13 **2012 Work RVU:** 0.13
2007 NF PE RVU: 1.1 **2012 NF PE RVU:** 1.49
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.13 and new PE inputs

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88304 **Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pathologic fracture, Bursa/synovial cyst, Carpal tunnel tissue, Cartilage, shavings, Cholesteatoma Colon, colostomy stoma, Conjunctiva - biopsy/pterygium, Cornea Diverticulum - esophagus/small intestine, Dupuytren's contracture tissue, Femoral head, other than fracture, Fissure/fistula, Foreskin, other than newborn, Gallbladder, Ganglion cyst, Hematoma, Hemorrhoids, Hydatid of Morgagni, Intervertebral disc, Joint, loose body, Meniscus Mucocele, salivary, Neuroma - Morton's/traumatic, Pilonidal cyst/sinus, Polyps, inflammatory - nasal/sinusoidal, Skin - cyst/tag/debridement, Soft tissue, debridement, Soft tissue, lipoma, Spermatocele, Tendon/tendon sheath, Testicular appendage, Thrombus or embolus, Tonsil and/or adenoids, Varicocele, Vas deferens, other than sterilization, Vein, varicosity**

Global: XXX **Issue:** Pathology Consultations **Screen:** Top 9 Harvard / Low Value-High Volume / CMS Request NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,103,248

2007 Work RVU: 0.22 **2012 Work RVU:** 0.22
2007 NF PE RVU: 1.37 **2012 NF PE RVU:** 1.58
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.22 and new PE inputs

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88305 **Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of surgical margins, Breast, reduction mammoplasty, Bronchus, biopsy, Cell block, any source, Cervix, biopsy, Colon, biopsy, Duodenum, biopsy, Endocervix, curettings/biopsy, Endometrium, curettings/biopsy, Esophagus, biopsy, Extremity, amputation, traumatic, Fallopian tube, biopsy, Fallopian tube, ectopic pregnancy, Femoral head, fracture, Fingers/toes, amputation, non-traumatic, Gingiva/oral mucosa, biopsy, Heart valve, Joint, resection, Kidney, biopsy, Larynx, biopsy, Leiomyoma(s), uterine myomectomy - without uterus, Lip, biopsy/wedge resection, Lung, transbronchial biopsy, Lymph node, biopsy, Muscle, biopsy, Nasal mucosa, biopsy, Nasopharynx/oropharynx, biopsy, Nerve, biopsy, Odontogenic/dental cyst, Omentum, biopsy, Ovary with or without tube, non-neoplastic, Ovary, biopsy/wedge resection, Parathyroid gland, Peritoneum, biopsy, Pituitary tumor, Placenta, other than third trimester, Pleura/pericardium - biopsy/tissue, Polyp, cervical/endometrial, Polyp, colorectal, Polyp, stomach/small intestine, Prostate, needle biopsy, Prostate, TUR, Salivary gland, biopsy, Sinus, paranasal biopsy, Skin, other than cyst/tag/debridement/plastic repair, Small intestine, biopsy, Soft tissue, other than tumor/mass/lipoma/debridement, Spleen, Stomach, biopsy, Synovium, Testis, other than tumor/biopsy/castration, Thyroglossal duct/brachial cleft cyst, Tongue, biopsy, Tonsil, biopsy, Trachea, biopsy, Ureter, biopsy, Urethra, biopsy, Urinary bladder, biopsy, Uterus, with or without tubes and ovaries, for prolapse, Vagina, biopsy, Vulva/labia, biopsy**

Global: XXX **Issue:** Pathology Consultations **Screen:** Top 9 Harvard / CMS Request NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2010 Medicare Utilization Data:** 16,231,440

2007 Work RVU: 0.75 **2012 Work RVU:** 0.75
2007 NF PE RVU: 1.97 **2012 NF PE RVU:** 2.34
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.75 and new PE inputs

CPT Action (if applicable):
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88307 **Level V - Surgical pathology, gross and microscopic examination Adrenal, resection, Bone - biopsy/curettings, Bone fragment(s), pathologic fracture, Brain, biopsy, Brain/meninges, tumor resection, Breast, excision of lesion, requiring microscopic evaluation of surgical margins, Breast, mastectomy - partial/simple, Cervix, conization, Colon, segmental resection, other than for tumor, Extremity, amputation, non-traumatic, Eye, enucleation, Kidney, partial/total nephrectomy, Larynx, partial/total resection, Liver, biopsy - needle/wedge, Liver, partial resection, Lung, wedge biopsy, Lymph nodes, regional resection, Mediastinum, mass, Myocardium, biopsy, Odontogenic tumor, Ovary with or without tube, neoplastic, Pancreas, biopsy, Placenta, third trimester, Prostate, except radical resection, Salivary gland, Sentinel lymph node, Small intestine, resection, other than for tumor, Soft tissue mass (except lipoma) - biopsy/simple excision, Stomach - subtotal/total resection, other than for tumor, Testis, biopsy, Thymus, tumor, Thyroid, total/lobe, Ureter, resection, Urinary bladder, TUR, Uterus, with or without tubes and ovaries, other than neoplastic/prolapse**

Global: XXX **Issue:** Pathology Consultations **Screen:** Top 9 Harvard / CMS Request NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2010 Medicare Utilization Data:** 865,568

2007 Work RVU: 1.59 **2012 Work RVU:** 1.59
2007 NF PE RVU: 3.48 **2012 NF PE RVU:** 5.25
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.59 and new PE inputs

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88309 **Level VI - Surgical pathology, gross and microscopic examination Bone resection, Breast, mastectomy - with regional lymph nodes, Colon, segmental resection for tumor, Colon, total resection, Esophagus, partial/total resection, Extremity, disarticulation, Fetus, with dissection, Larynx, partial/total resection - with regional lymph nodes, Lung - total/lobe/segment resection, Pancreas, total/subtotal resection, Prostate, radical resection, Small intestine, resection for tumor, Soft tissue tumor, extensive resection, Stomach - subtotal/total resection for tumor, Testis, tumor, Tongue/tonsil -resection for tumor, Urinary bladder, partial/total resection, Uterus, with or without tubes and ovaries, neoplastic, Vulva, total/subtotal resection**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard / CMS Request NPRM for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2010 Medicare Utilization Data:** 164,583

2007 Work RVU: 2.80 **2012 Work RVU:** 2.8
2007 NF PE RVU: 4.86 **2012 NF PE RVU:** 7.53
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 2.80 and new PE inputs

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88312 **Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)**

Global: XXX **Issue:** Special Stains **Screen:** Top 9 Harvard / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,366,477

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 1.76 **2012 NF PE RVU:** 2.19
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.54 **CPT Action (if applicable):** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88313 **Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry**

Global: XXX **Issue:** Special Stains **Screen:** Top 9 Harvard / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,355,127

2007 Work RVU: 0.24 **2012 Work RVU:** 0.24
2007 NF PE RVU: 1.42 **2012 NF PE RVU:** 1.67
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.24 **CPT Action (if applicable):** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88314 **Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Special Stains **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2010 Medicare Utilization Data:** 21,727

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 2.04 **2012 NF PE RVU:** 1.88
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.45 **CPT Action (if applicable):** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88318 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Special Stains **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 22 **Specialty Developing Recommendation:** CAP, AAD **First Identified:** **2010 Medicare Utilization Data:** 779

2007 Work RVU: 0.42 **2012 Work RVU:**
2007 NF PE RVU: 1.98 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** June 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88319 **Special stain including interpretation and report; Group III, for enzyme constituents** **Global:** XXX **Issue:** Special Stains **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** **2010 Medicare Utilization Data:** 16,706

2007 Work RVU: 0.53 **2012 Work RVU:** 0.53
2007 NF PE RVU: 3.36 **2012 NF PE RVU:** 2.31
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.53 **CPT Action (if applicable):** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88329 **Pathology consultation during surgery;** **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** February 2010 **2010 Medicare Utilization Data:** 36,148

2007 Work RVU: 0.67 **2012 Work RVU:** 0.67
2007 NF PE RVU: 0.66 **2012 NF PE RVU:** 0.85
2007 Fac PE RVU: 0.27 **2012 Fac PE RVU:** 0.30

RUC Recommendation: 0.67 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88331 **Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen** **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 559,730

2007 Work RVU: 1.19 **2012 Work RVU:** 1.19
2007 NF PE RVU: 1.14 **2012 NF PE RVU:** 1.51
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.19 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88332 **Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2010 Medicare Utilization Data:** 179,613

2007 Work RVU: 0.59 **2012 Work RVU:** 0.59
2007 NF PE RVU: 0.46 **2012 NF PE RVU:** 0.59
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.59 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88342 **Immunohistochemistry (including tissue immunoperoxidase), each antibody**

Global: XXX **Issue:** RAW review **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** CAP **First Identified:** April 2011 **2010 Medicare Utilization Data:** 3,471,757

2007 Work RVU: 0.85 **2012 Work RVU:** 0.85
2007 NF PE RVU: 1.6 **2012 NF PE RVU:** 2.21
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

88365 **In situ hybridization (eg, FISH), each probe**

Global: XXX **Issue:** **Screen:** CMS Request - NPRM for 2012 **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 39,017

2007 Work RVU: 1.20 **2012 Work RVU:** 1.2
2007 NF PE RVU: 2.32 **2012 NF PE RVU:** 3.63
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review at the RAW **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88367 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology**

Global: XXX **Issue:** **Screen:** CMS Request - NPRM for 2012 **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 503,924

2007 Work RVU: 1.30 **2012 Work RVU:** 1.3
2007 NF PE RVU: 4.31 **2012 NF PE RVU:** 6.40
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review at the RAW **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:**

88368 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual**

Global: XXX **Issue:** **Screen:** CMS Request - NPRM for 2012 **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 346,294

2007 Work RVU: 1.40 **2012 Work RVU:** 1.4
2007 NF PE RVU: 2.96 **2012 NF PE RVU:** 5.05
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review at the RAW **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:**

88375 **Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session**

Global: **Issue:** Optical Endomicroscopy **Screen:** MPC List **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, CAP **First Identified:** September 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price **CPT Action (if applicable):** **Result:** Carrier Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

90465 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2010 Medicare Utilization Data:** 99

2007 Work RVU: 0.17 **2012 Work RVU:**
2007 NF PE RVU: 0.35 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90467 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2010 Medicare Utilization Data:** 1

2007 Work RVU: 0.17 **2012 Work RVU:**
2007 NF PE RVU: 0.17 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.09 **2012 Fac PE RVU:**

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90471 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 840,272

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.35 **2012 NF PE RVU:** 0.53
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90472 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2010 Medicare Utilization Data:** 33,327

2007 Work RVU: 0.15 **2012 Work RVU:** 0.15
2007 NF PE RVU: 0.13 **2012 NF PE RVU:** 0.19
2007 Fac PE RVU: 0.11 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90473 **Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2010 Medicare Utilization Data:** 649

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.18 **2012 NF PE RVU:** 0.47
2007 Fac PE RVU: 0.06 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90474 **Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2010 Medicare Utilization Data:** 67

2007 Work RVU: 0.15 **2012 Work RVU:** 0.15
2007 NF PE RVU: 0.09 **2012 NF PE RVU:** 0.18
2007 Fac PE RVU: 0.05 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90785 **Interactive Complexity (List separately in addition to the code for primary procedure)**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price **CPT Action (if applicable):** February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90791 **Psychiatric diagnostic evaluation** **Global:** **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 3.00 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90792 **Psychiatric diagnostic evaluation with medical services** **Global:** **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 3.25 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90801 **Psychiatric diagnostic interview examination** **Global:** XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,503,165

2007 Work RVU: 2.80 **2012 Work RVU:** 2.8
2007 NF PE RVU: 1.25 **2012 NF PE RVU:** 1.57
2007 Fac PE RVU: 0.85 **2012 Fac PE RVU:** 0.61

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90805 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,504,700

2007 Work RVU: 1.37 **2012 Work RVU:** 1.37
2007 NF PE RVU: 0.53 **2012 NF PE RVU:** 0.69
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** 0.27

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90806 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 6,270,189

2007 Work RVU: 1.86 **2012 Work RVU:** 1.86
2007 NF PE RVU: 0.66 **2012 NF PE RVU:** 0.48
2007 Fac PE RVU: 0.53 **2012 Fac PE RVU:** 0.27

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90808 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 397,593

2007 Work RVU: 2.79 **2012 Work RVU:** 2.79
2007 NF PE RVU: 0.94 **2012 NF PE RVU:** 0.63
2007 Fac PE RVU: 0.8 **2012 Fac PE RVU:** 0.42

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90818 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,448,066

2007 Work RVU: 1.89 **2012 Work RVU:** 1.89
2007 NF PE RVU: NA **2012 NF PE RVU:** 0.30
2007 Fac PE RVU: 0.63 **2012 Fac PE RVU:** 0.38

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90832 **Psychotherapy, 30 minutes with patient and/or family member**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

First Identified: **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.50

CPT Action (if applicable): February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90833 **Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

First Identified: **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.50

CPT Action (if applicable): February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90834 **Psychotherapy, 45 minutes with patient and/or family member**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.00 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90836 **Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.90 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90837 **Psychotherapy, 60 minutes with patient and/or family member**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 3.00 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90838 **Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.50 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90839 **Psychotherapy for crisis, first 60 minutes;**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price **CPT Action (if applicable):** February 2012 **Result:** Carrier Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

90840 **Psychotherapy for crisis, first 60 minutes; each additional 30 minutes (List separately in addition to code for primary service)**

Global: **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price **CPT Action (if applicable):** February 2012 **Result:** Carrier Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90845 **Psychoanalysis** **Global:** **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: October 2011 **Tab** **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.10 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90846 **Family psychotherapy (without the patient present)** **Global:** **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.40 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90847 **Family psychotherapy (conjoint psychotherapy) (with patient present)** **Global:** **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.50 **CPT Action (if applicable):** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90853 **Group psychotherapy (other than of a multiple-family group)** **Global:** **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.59 **CPT Action (if applicable):** February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90862 **Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 5,348,548

2007 Work RVU: 0.95 **2012 Work RVU:** 0.95
2007 NF PE RVU: 0.46 **2012 NF PE RVU:** 0.73
2007 Fac PE RVU: 0.31 **2012 Fac PE RVU:** 0.31

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90863 **Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

Global: **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 55 **Specialty Developing Recommendation:** APA (HCPAC) **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Carrier Price **CPT Action (if applicable):** February 2012 **Result:** Carrier Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

90870 **Electroconvulsive therapy (includes necessary monitoring)**

Global: 000 **Issue:** Electroconvulsive Therapy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 41 **Specialty Developing Recommendation:** APA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 135,045

2007 Work RVU: 1.88 **2012 Work RVU:** 2.5
2007 NF PE RVU: 1.93 **2012 NF PE RVU:** 2.34
2007 Fac PE RVU: 0.54 **2012 Fac PE RVU:** 0.52

RUC Recommendation: 2.50 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90935 **Hemodialysis procedure with single physician evaluation**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,367,649

2007 Work RVU: 1.22 **2012 Work RVU:** 1.48
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 0.64 **2012 Fac PE RVU:** 0.58

RUC Recommendation: 1.48 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90937 **Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 90,344

2007 Work RVU: 2.11 **2012 Work RVU:** 2.11
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU:0.93 **2012 Fac PE RVU:**0.83

RUC Recommendation: 2.11 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

90945 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 127,219

2007 Work RVU: 1.28 **2012 Work RVU:** 1.56
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU:0.66 **2012 Fac PE RVU:**0.81

RUC Recommendation: 1.56 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90947 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 16,160

2007 Work RVU: 2.16 **2012 Work RVU:** 2.52
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU:0.94 **2012 Fac PE RVU:**0.94

RUC Recommendation: 2.52 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90951 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 50

2007 Work RVU: **2012 Work RVU:** 18.46
2007 NF PE RVU: **2012 NF PE RVU:** 7.87
2007 Fac PE RVU: **2012 Fac PE RVU:** 7.87

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90952 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 9

2007 Work RVU: **2012 Work RVU:** 0
2007 NF PE RVU: **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90953 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 20

2007 Work RVU: **2012 Work RVU:** 0
2007 NF PE RVU: **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90954 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 448

2007 Work RVU: **2012 Work RVU:** 15.98
2007 NF PE RVU: **2012 NF PE RVU:** 6.45
2007 Fac PE RVU: **2012 Fac PE RVU:** 6.45

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90955 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 96

2007 Work RVU: **2012 Work RVU:** 8.79
2007 NF PE RVU: **2012 NF PE RVU:** 3.91
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.91

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90956 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 166

2007 Work RVU: **2012 Work RVU:** 5.95
2007 NF PE RVU: **2012 NF PE RVU:** 2.83
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.83

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90957 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 3,087

2007 Work RVU: **2012 Work RVU:** 12.52
2007 NF PE RVU: **2012 NF PE RVU:** 5.41
2007 Fac PE RVU: **2012 Fac PE RVU:** 5.41

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90958 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 931

2007 Work RVU: **2012 Work RVU:** 8.34
2007 NF PE RVU: **2012 NF PE RVU:** 3.82
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.82

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90959 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 592

2007 Work RVU: **2012 Work RVU:** 5.5
2007 NF PE RVU: **2012 NF PE RVU:** 2.68
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.68

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90960 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 2,094,884

2007 Work RVU: **2012 Work RVU:** 5.18
2007 NF PE RVU: **2012 NF PE RVU:** 2.80
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.80
Result: PE Only

RUC Recommendation: RUC Recommended revised physician and clinical staff time

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

90961 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 622,643

2007 Work RVU: **2012 Work RVU:** 4.26
2007 NF PE RVU: **2012 NF PE RVU:** 2.38
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.38
Result: PE Only

RUC Recommendation: RUC Recommended revised physician and clinical staff time

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

90962 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 187,916

2007 Work RVU: **2012 Work RVU:** 3.15
2007 NF PE RVU: **2012 NF PE RVU:** 1.90
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.90
Result: PE Only

RUC Recommendation: RUC Recommended revised clinical staff time

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90963 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 373

2007 Work RVU: **2012 Work RVU:** 10.56
2007 NF PE RVU: **2012 NF PE RVU:** 4.66
2007 Fac PE RVU: **2012 Fac PE RVU:** 4.66

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90964 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 849

2007 Work RVU: **2012 Work RVU:** 9.14
2007 NF PE RVU: **2012 NF PE RVU:** 3.95
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.95

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90965 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 1,925

2007 Work RVU: **2012 Work RVU:** 8.69
2007 NF PE RVU: **2012 NF PE RVU:** 3.79
2007 Fac PE RVU: **2012 Fac PE RVU:** 3.79

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90966 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2010 Medicare Utilization Data:** 222,157

2007 Work RVU: **2012 Work RVU:** 4.26
2007 NF PE RVU: **2012 NF PE RVU:** 2.35
2007 Fac PE RVU: **2012 Fac PE RVU:** 2.35

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91038 **Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)**

Global: 000 **Issue:** Gastroenterological Tests **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 23 **Specialty Developing Recommendation:** AGA, ASGE **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,952

2007 Work RVU: 1.10 **2012 Work RVU:** 1.1
2007 NF PE RVU: 2.36 **2012 NF PE RVU:** 10.62
2007 Fac PE RVU: 2.36 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91132 **Electrogastrography, diagnostic, transcutaneous;**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2010 Medicare Utilization Data:** 46

2007 Work RVU: 0.00 **2012 Work RVU:** 0.52
2007 NF PE RVU: 0 **2012 NF PE RVU:** 4.14
2007 Fac PE RVU: 0 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

91133 **Electrogastrography, diagnostic, transcutaneous; with provocative testing**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2010 Medicare Utilization Data:** 43

2007 Work RVU: 0.00 **2012 Work RVU:** 0.66
2007 NF PE RVU: 0 **2012 NF PE RVU:** 4.75
2007 Fac PE RVU:0 **2012 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

92081 **Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2010 Medicare Utilization Data:** 117,269

2007 Work RVU: 0.36 **2012 Work RVU:** 0.3
2007 NF PE RVU: 0.95 **2012 NF PE RVU:** 1.10
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 0.30 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92082 **Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2010 Medicare Utilization Data:** 176,773

2007 Work RVU: 0.44 **2012 Work RVU:** 0.4
2007 NF PE RVU: 1.26 **2012 NF PE RVU:** 1.60
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 0.40 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92083 **Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)**

Global: XXX **Issue:** Visual Field Examination **Screen:** MPC List / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 46 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2010 **2010 Medicare Utilization Data:** 2,608,270

2007 Work RVU: 0.50 **2012 Work RVU:** 0.5
2007 NF PE RVU: 1.46 **2012 NF PE RVU:** 2.09
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.50 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92100 **Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)**

Global: XXX **Issue:** Serial Tonometry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 36 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2010 Medicare Utilization Data:** 34,069

2007 Work RVU: 0.92 **2012 Work RVU:** 0.92
2007 NF PE RVU: 1.33 **2012 NF PE RVU:** 1.81
2007 Fac PE RVU: 0.35 **2012 Fac PE RVU:** 0.48

RUC Recommendation: 0.61 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92133 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.5
2007 NF PE RVU: **2012 NF PE RVU:** 0.78
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.50 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92134 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.5
2007 NF PE RVU: **2012 NF PE RVU:** 0.78
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.50 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92135 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 31 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 10,033,241

2007 Work RVU: 0.35 **2012 Work RVU:**
2007 NF PE RVU: 0.79 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92136 **Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation**

Global: XXX **Issue:** Ophthalmologic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO, AOA, ASCRS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,198,737

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 1.6 **2012 NF PE RVU:** 2.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92235 **Fluorescein angiography (includes multiframe imaging) with interpretation and report**

Global: XXX **Issue:** Fluorescein Angiography **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 26 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2010 Medicare Utilization Data:** 1,472,186

2007 Work RVU: 0.81 **2012 Work RVU:** 0.81
2007 NF PE RVU: 2.54 **2012 NF PE RVU:** 3.18
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.81 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92250 **Fundus photography with interpretation and report**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 2,162,922

2007 Work RVU: 0.44 **2012 Work RVU:** 0.44
2007 NF PE RVU: 1.48 **2012 NF PE RVU:** 1.79
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92270 **Electro-oculography with interpretation and report**

Global: XXX **Issue:** Electro-oculography **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 15,917

2007 Work RVU: 0.81 **2012 Work RVU:** 0.81
2007 NF PE RVU: 1.5 **2012 NF PE RVU:** 1.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review September 2013. CPT Assistant article published. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2008 and Q&A

Status Report: CMS Requests and Relativity Assessment Issues

92285 **External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)**

Global: XXX **Issue:** Ocular Photography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 32 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 305,350

2007 Work RVU: 0.20 **2012 Work RVU:** 0.05
2007 NF PE RVU: 0.95 **2012 NF PE RVU:** 0.65
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.05 and new PE inputs **CPT Action (if applicable):** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92286 **Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2010 Medicare Utilization Data:** 113,864

2007 Work RVU: 0.66 **2012 Work RVU:** 0.66
2007 NF PE RVU: 2.83 **2012 NF PE RVU:** 2.92
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.40 **CPT Action (if applicable):** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92287 **Special anterior segment photography with interpretation and report; with fluorescein angiography**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** **2010 Medicare Utilization Data:** 2,958

2007 Work RVU: 0.81 **2012 Work RVU:** 0.81
2007 NF PE RVU: 2.28 **2012 NF PE RVU:** 2.73
2007 Fac PE RVU: 0.31 **2012 Fac PE RVU:** 0.49

RUC Recommendation: Refer to CPT Asst. **CPT Action (if applicable):** October 2011 **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92504 **Binocular microscopy (separate diagnostic procedure)** **Global:** XXX **Issue:** Binocular Microscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 43 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2009 **2010 Medicare Utilization Data:** 178,730

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.51 **2012 NF PE RVU:** 0.72
2007 Fac PE RVU: 0.08 **2012 Fac PE RVU:** 0.09

RUC Recommendation: 0.18 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92506 **Evaluation of speech, language, voice, communication, and/or auditory processing** **Global:** XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 20,249

2007 Work RVU: 0.86 **2012 Work RVU:** 0.86
2007 NF PE RVU: 2.76 **2012 NF PE RVU:** 3.95
2007 Fac PE RVU: 0.36 **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** June 2012 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

92507 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual** **Global:** XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 82,310

2007 Work RVU: 0.52 **2012 Work RVU:** 1.3
2007 NF PE RVU: 1.13 **2012 NF PE RVU:** 0.83
2007 Fac PE RVU: 0.21 **2012 Fac PE RVU:** NA

RUC Recommendation: 1.30 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92508 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 710

2007 Work RVU: 0.26 **2012 Work RVU:** 0.33
2007 NF PE RVU: 0.51 **2012 NF PE RVU:** 0.32
2007 Fac PE RVU: 0.11 **2012 Fac PE RVU:** NA

RUC Recommendation: 0.43 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92526 **Treatment of swallowing dysfunction and/or oral function for feeding**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 39 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 26,466

2007 Work RVU: 0.55 **2012 Work RVU:** 1.34
2007 NF PE RVU: 1.65 **2012 NF PE RVU:** 1.03
2007 Fac PE RVU: 0.19 **2012 Fac PE RVU:** NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92540 **Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** **2010 Medicare Utilization Data:** 93,845

2007 Work RVU: **2012 Work RVU:** 1.5
2007 NF PE RVU: **2012 NF PE RVU:** 1.39
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.50 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92541 **Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 38,587

2007 Work RVU: 0.40 **2012 Work RVU:** 0.4
2007 NF PE RVU: 1.05 **2012 NF PE RVU:** 0.68
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.40 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92542 **Positional nystagmus test, minimum of 4 positions, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 18,687

2007 Work RVU: 0.33 **2012 Work RVU:** 0.33
2007 NF PE RVU: 1.16 **2012 NF PE RVU:** 0.71
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.33 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92543 **Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 392,675

2007 Work RVU: 0.10 **2012 Work RVU:** 0.1
2007 NF PE RVU: 0.59 **2012 NF PE RVU:** 0.45
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.10 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92544 **Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 5,133

2007 Work RVU: 0.26 **2012 Work RVU:** 0.26
2007 NF PE RVU: 0.93 **2012 NF PE RVU:** 0.60
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.26 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92545 **Oscillating tracking test, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 6,326

2007 Work RVU: 0.23 **2012 Work RVU:** 0.23
2007 NF PE RVU: 0.85 **2012 NF PE RVU:** 0.57
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.23 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92550 **Tympanometry and reflex threshold measurements**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2010 Medicare Utilization Data:** 240,268

2007 Work RVU: **2012 Work RVU:** 0.35
2007 NF PE RVU: **2012 NF PE RVU:** 0.25
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.35 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92557 **Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,090,191

2007 Work RVU: 0.00 **2012 Work RVU:** 0.6
2007 NF PE RVU: 1.21 **2012 NF PE RVU:** 0.52
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.38

RUC Recommendation: 0.60 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92558 **Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0
2007 NF PE RVU: **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.00

RUC Recommendation: 0.17 **CPT Action (if applicable):** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92567 **Tympanometry (impedance testing)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 654,991

2007 Work RVU: 0.00 **2012 Work RVU:** 0.2
2007 NF PE RVU: 0.51 **2012 NF PE RVU:** 0.23
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.13

RUC Recommendation: 0.20 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92568 **Acoustic reflex testing, threshold**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:** 73,776

2007 Work RVU: 0.00 **2012 Work RVU:** 0.29
2007 NF PE RVU: 0.32 **2012 NF PE RVU:** 0.17
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.17

RUC Recommendation: 0.29 work RVU and clinical staff time removed **CPT Action (if applicable):** February 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92569 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0.35 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92570 **Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2010 Medicare Utilization Data:** 69,432

2007 Work RVU: **2012 Work RVU:** 0.55
2007 NF PE RVU: **2012 NF PE RVU:** 0.36
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.29

RUC Recommendation: 0.55 **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92587 **Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2008 **2010 Medicare Utilization Data:** 62,488

2007 Work RVU: 0.13 **2012 Work RVU:** 0.35
2007 NF PE RVU: 1.19 **2012 NF PE RVU:** 0.44
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.45 **CPT Action (if applicable):** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92588 **Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 138,056

2007 Work RVU: 0.36 **2012 Work RVU:** 0.55
2007 NF PE RVU: 1.48 **2012 NF PE RVU:** 0.68
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.60 **CPT Action (if applicable):** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92597 **Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 30 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2010 Medicare Utilization Data:** 2,619

2007 Work RVU: 0.86 **2012 Work RVU:** 1.26
2007 NF PE RVU: 1.69 **2012 NF PE RVU:** 1.11
2007 Fac PE RVU: 0.4 **2012 Fac PE RVU:** NA

RUC Recommendation: 1.48 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92605 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: 0.00 **2012 Work RVU:** 1.75
2007 NF PE RVU: 0 **2012 NF PE RVU:** 0.83
2007 Fac PE RVU: 0 **2012 Fac PE RVU:** 0.71

RUC Recommendation: 1.75 **CPT Action (if applicable):** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92606 **Therapeutic service(s) for the use of non-speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: 0.00 **2012 Work RVU:** 1.4
2007 NF PE RVU: 0 **2012 NF PE RVU:** 0.91
2007 Fac PE RVU:0 **2012 Fac PE RVU:**0.57

RUC Recommendation: 1.40 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92607 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 362

2007 Work RVU: 0.00 **2012 Work RVU:** 1.85
2007 NF PE RVU: 3.38 **2012 NF PE RVU:** 2.24
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 1.85 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92608 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 140

2007 Work RVU: 0.00 **2012 Work RVU:** 0.7
2007 NF PE RVU: 0.63 **2012 NF PE RVU:** 0.61
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 0.70 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92609 **Therapeutic services for the use of speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:** 2,844

2007 Work RVU: 0.00 **2012 Work RVU:** 1.5
2007 NF PE RVU: 1.77 **2012 NF PE RVU:** 1.40
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.50 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92610 **Evaluation of oral and pharyngeal swallowing function**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 30 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 11,392

2007 Work RVU: 0.00 **2012 Work RVU:** 1.3
2007 NF PE RVU: 2.98 **2012 NF PE RVU:** 1.26
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.60

RUC Recommendation: 1.30 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92611 **Motion fluoroscopic evaluation of swallowing function by cine or video recording**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 39 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2010 Medicare Utilization Data:** 7,976

2007 Work RVU: 0.00 **2012 Work RVU:** 1.34
2007 NF PE RVU: 3.04 **2012 NF PE RVU:** 1.47
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92618 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.65
2007 NF PE RVU: **2012 NF PE RVU:** 0.28
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.26

RUC Recommendation: 0.65 **CPT Action (if applicable):** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92620 **Evaluation of central auditory function, with report; initial 60 minutes**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 1,254

2007 Work RVU: 0.00 **2012 Work RVU:** 1.5
2007 NF PE RVU: 1.32 **2012 NF PE RVU:** 1.02
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.77

RUC Recommendation: 1.50 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92621 **Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 38

2007 Work RVU: 0.00 **2012 Work RVU:** 0.35
2007 NF PE RVU: 0.29 **2012 NF PE RVU:** 0.26
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.17

RUC Recommendation: 0.35 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92625 **Assessment of tinnitus (includes pitch, loudness matching, and masking)** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 5,764

2007 Work RVU: 0.00 **2012 Work RVU:** 1.15
2007 NF PE RVU: 1.3 **2012 NF PE RVU:** 0.76
2007 Fac PE RVU: 1.3 **2012 Fac PE RVU:** 0.58

RUC Recommendation: 1.15 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92626 **Evaluation of auditory rehabilitation status; first hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 14,127

2007 Work RVU: 0.00 **2012 Work RVU:** 1.4
2007 NF PE RVU: 2.11 **2012 NF PE RVU:** 1.11
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.78

RUC Recommendation: 1.40 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92627 **Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 3,366

2007 Work RVU: 0.00 **2012 Work RVU:** 0.33
2007 NF PE RVU: 0.52 **2012 NF PE RVU:** 0.30
2007 Fac PE RVU: 0.52 **2012 Fac PE RVU:** 0.19

RUC Recommendation: 0.33 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92640 **Diagnostic analysis with programming of auditory brainstem implant, per hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2010 Medicare Utilization Data:** 14

2007 Work RVU: 0.00 **2012 Work RVU:** 1.76
2007 NF PE RVU: 1.4 **2012 NF PE RVU:** 1.20
2007 Fac PE RVU: 1.4 **2012 Fac PE RVU:** 0.78

RUC Recommendation: 1.76 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92920 **Percutaneous transluminal coronary angioplasty; single major coronary artery or branch**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 9.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92921 **Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 4.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92924 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 11.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92925 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 5.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92928 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 10.49 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92929 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 4.44 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92933 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 12.32 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92934 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 5.50 **CPT Action (if applicable):** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92937 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 10.49 **CPT Action (if applicable):** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92938 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 6.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92941 **Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 12.32 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92943 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 12.32 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92944 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 6.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92960 **Cardioversion, elective, electrical conversion of arrhythmia; external**

Global: 000 **Issue:** Cardioversion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 19 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2010 Medicare Utilization Data:** 135,541

2007 Work RVU: 2.25 **2012 Work RVU:** 2.25
2007 NF PE RVU: 5.83 **2012 NF PE RVU:** 4.02
2007 Fac PE RVU: 1.25 **2012 Fac PE RVU:** 1.24

RUC Recommendation: 2.25 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92980 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:** 322,682

2007 Work RVU: 14.82 **2012 Work RVU:** 14.82
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.65 **2012 Fac PE RVU:** 6.55

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92981 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:** 38,315

2007 Work RVU: 4.16 **2012 Work RVU:** 4.16
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.8 **2012 Fac PE RVU:** 1.78

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92982 **Percutaneous transluminal coronary balloon angioplasty; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:** 26,848

2007 Work RVU: 10.96 **2012 Work RVU:** 10.96
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 4.97 **2012 Fac PE RVU:** 4.90

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92984 **Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:** 7,153

2007 Work RVU: 2.97 **2012 Work RVU:** 2.97
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.28 **2012 Fac PE RVU:** 1.27

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92986 **Percutaneous balloon valvuloplasty; aortic valve**

Global: 090 **Issue:** Valvuloplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:** 2,744

2007 Work RVU: 22.70 **2012 Work RVU:** 22.85
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 12.84 **2012 Fac PE RVU:** 12.91

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

92995 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,167

2007 Work RVU: 12.07 **2012 Work RVU:** 12.07
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 5.45 **2012 Fac PE RVU:** 5.38

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92996 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2010 Medicare Utilization Data:** 231

2007 Work RVU: 3.26 **2012 Work RVU:** 3.26
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 1.41 **2012 Fac PE RVU:** 1.39

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93000 **Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report**

Global: XXX **Issue:** RAW Review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 11,783,610

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.47 **2012 NF PE RVU:** 0.37
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for the October 2012 meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

93005 **Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report**

Global: XXX **Issue:** Echocardiography **Screen:** High Volume Growth / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACEP

First Identified: February 2008 **2010 Medicare Utilization Data:** 701,492

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.41 **2012 NF PE RVU:** 0.30
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for the October 2012 meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

93010 **Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only**

Global: XXX **Issue:** **Screen:** MPC List / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: October 2010 **2010 Medicare Utilization Data:** 19,647,347

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.06 **2012 NF PE RVU:** 0.07
2007 Fac PE RVU: 0.06 **2012 Fac PE RVU:** 0.07

RUC Recommendation: Survey for work and PE for the October 2012 meeting.

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93012 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 9,372

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 5.55 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93014 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 26,172

2007 Work RVU: 0.52 **2012 Work RVU:**
2007 NF PE RVU: 0.2 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93015 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,711,584

2007 Work RVU: 0.75 **2012 Work RVU:** 0.75
2007 NF PE RVU: 1.95 **2012 NF PE RVU:** 1.82
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.75. CPT Assistant published. **CPT Action (if applicable):** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

Status Report: CMS Requests and Relativity Assessment Issues

93016 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,122,304

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.19 **2012 NF PE RVU:** 0.19
2007 Fac PE RVU: 0.19 **2012 Fac PE RVU:** 0.19

RUC Recommendation: 0.45 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93017 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** High Volume Growth / CMS Request - Practice Expense Review / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 181,692

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 1.64 **2012 NF PE RVU:** 1.50
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93018 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only**

Global: XXX **Issue:** Cardiovascular Stress Tests and Echocardiography **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,293,317

2007 Work RVU: 0.30 **2012 Work RVU:** 0.3
2007 NF PE RVU: 0.12 **2012 NF PE RVU:** 0.13
2007 Fac PE RVU: 0.12 **2012 Fac PE RVU:** 0.13

RUC Recommendation: 0.30 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

Status Report: CMS Requests and Relativity Assessment Issues

93025 **Microvolt T-wave alternans for assessment of ventricular arrhythmias**

Global: XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 18 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2010 Medicare Utilization Data:** 5,061

2007 Work RVU: 0.75 **2012 Work RVU:** 0.75
2007 NF PE RVU: 6.67 **2012 NF PE RVU:** 4.52
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93040 **Rhythm ECG, 1-3 leads; with interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 34 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2010 Medicare Utilization Data:** 152,998

2007 Work RVU: 0.16 **2012 Work RVU:** 0.15
2007 NF PE RVU: 0.2 **2012 NF PE RVU:** 0.21
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.15 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93041 **Rhythm ECG, 1-3 leads; tracing only without interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 34 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2010 Medicare Utilization Data:** 17,143

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.15 **2012 NF PE RVU:** 0.16
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.00 (PE only) **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93042 **Rhythm ECG, 1-3 leads; interpretation and report only**

Global: XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 34 **Specialty Developing Recommendation:** ACC, ACEP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 878,371

2007 Work RVU: 0.16 **2012 Work RVU:** 0.15
2007 NF PE RVU: 0.05 **2012 NF PE RVU:** 0.05
2007 Fac PE RVU: 0.05 **2012 Fac PE RVU:** 0.05

RUC Recommendation: 0.15 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93224 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2010 Medicare Utilization Data:** 221,981

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 3.29 **2012 NF PE RVU:** 2.36
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.52 **CPT Action (if applicable):** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93225 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 71,686

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 1.2 **2012 NF PE RVU:** 0.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: N/A no physician work **CPT Action (if applicable):** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93226 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 65,865

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 1.88 **2012 NF PE RVU:** 1.26
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: N/A no physician work **CPT Action (if applicable):** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93227 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; physician review and interpretation**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2010 Medicare Utilization Data:** 255,481

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 0.21 **2012 NF PE RVU:** 0.25
2007 Fac PE RVU: 0.21 **2012 Fac PE RVU:** 0.25

RUC Recommendation: 0.52 **CPT Action (if applicable):** Feburary 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93228 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 56,041

2007 Work RVU: **2012 Work RVU:** 0.52
2007 NF PE RVU: **2012 NF PE RVU:** 0.20
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.20

RUC Recommendation: 0.52 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93229 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 82,117

2007 Work RVU: **2012 Work RVU:** 0
2007 NF PE RVU: **2012 NF PE RVU:** 20.38
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: Contractor Priced **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93230 **Deleted from CPT**

Global: XXX **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2010 Medicare Utilization Data:** 344,582

2007 Work RVU: 0.52 **2012 Work RVU:**
2007 NF PE RVU: 3.49 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93231 **Deleted from CPT**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 71,281

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 1.37 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93232 **Deleted from CPT**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 107,563

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 1.92 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93233 **Deleted from CPT** **Global:** XXX **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2010 Medicare Utilization Data:** 135,238

2007 Work RVU: 0.52 **2012 Work RVU:**
2007 NF PE RVU: 0.2 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93235 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 6,242

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93236 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Cardiovascular Stress Test **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 8,967

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93237 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Wearable Cardiac Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2010 Medicare Utilization Data:** 121,118

2007 Work RVU: 0.45 **2012 Work RVU:**
2007 NF PE RVU: 0.18 **2012 NF PE RVU:**
2007 Fac PE RVU: 0.18 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93268 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, physician review and interpretation**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 23,750

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 7.02 **2012 NF PE RVU:** 6.45
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.52 **CPT Action (if applicable):** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93270 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 48,137

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 1 **2012 NF PE RVU:** 0.35
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** February 2010 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93271 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 57,902

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 5.82 **2012 NF PE RVU:** 5.90
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** February 2010 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93272 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; physician review and interpretation**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:** 75,071

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 0.2 **2012 NF PE RVU:** 0.20
2007 Fac PE RVU: 0.2 **2012 Fac PE RVU:** 0.20

RUC Recommendation: 0.52 **CPT Action (if applicable):** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93307 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography**

Global: XXX **Issue:** Cardiology Services **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2010 Medicare Utilization Data:** 93,293

2007 Work RVU: 0.92 **2012 Work RVU:** 0.92
2007 NF PE RVU: 4.1 **2012 NF PE RVU:** 2.93
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93308 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study**

Global: XXX **Issue:** Echocardiography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:** 158,574

2007 Work RVU: 0.53 **2012 Work RVU:** 0.53
2007 NF PE RVU: 2.26 **2012 NF PE RVU:** 2.44
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

93308 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study**

Global: XXX **Issue:** Transthoracic Echocardiography **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 39 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2010 Medicare Utilization Data:** 158,574

2007 Work RVU: 0.53 **2012 Work RVU:** 0.53
2007 NF PE RVU: 2.26 **2012 NF PE RVU:** 2.44
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.53 **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93320 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete**

Global: ZZZ **Issue:** Cardiology Services **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2010 Medicare Utilization Data:** 354,057

2007 Work RVU: 0.38 **2012 Work RVU:** 0.38
2007 NF PE RVU: 1.82 **2012 NF PE RVU:** 1.19
2007 Fac PE RVU: 1.82 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

93325 **Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)**

Global: ZZZ **Issue:** Cardiology Services **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2010 Medicare Utilization Data:** 463,975

2007 Work RVU: 0.07 **2012 Work RVU:** 0.07
2007 NF PE RVU: 2.36 **2012 NF PE RVU:** 0.74
2007 Fac PE RVU: 2.36 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93350 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;**

Global: XXX **Issue:** Stress Echo with ECG Monitoring **Screen:** Other - Identified by RUC / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC **First Identified:** April 2008 **2010 Medicare Utilization Data:** 181,808

2007 Work RVU: 1.48 **2012 Work RVU:** 1.46
2007 NF PE RVU: 3.03 **2012 NF PE RVU:** 4.58
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.46; CPT Assistant article published **CPT Action (if applicable):** October 2010 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93451 **Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2.72
2007 NF PE RVU: **2012 NF PE RVU:** 20.22
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 3.02 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93452 **Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4.75
2007 NF PE RVU: **2012 NF PE RVU:** 20.09
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 4.32 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93453 **Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.24
2007 NF PE RVU: **2012 NF PE RVU:** 26.30
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 5.98 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93454 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 4.79
2007 NF PE RVU: **2012 NF PE RVU:** 20.85
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 4.95 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93455 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.54
2007 NF PE RVU: **2012 NF PE RVU:** 24.42
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 6.15 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93456 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.15
2007 NF PE RVU: **2012 NF PE RVU:** 25.92
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 6.00 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93457 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.89
2007 NF PE RVU: **2012 NF PE RVU:** 29.48
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 7.66 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93458 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 5.85
2007 NF PE RVU: **2012 NF PE RVU:** 25.08
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 6.51 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93459 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 6.6
2007 NF PE RVU: **2012 NF PE RVU:** 27.55
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 7.34 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93460 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 7.35
2007 NF PE RVU: **2012 NF PE RVU:** 29.10
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 7.88 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93461 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 8.1
2007 NF PE RVU: **2012 NF PE RVU:** 33.76
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 9.00 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93462 **Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 3.73
2007 NF PE RVU: **2012 NF PE RVU:** 1.39
2007 Fac PE RVU: **2012 Fac PE RVU:** 1.39

RUC Recommendation: 3.73 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93463 **Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2
2007 NF PE RVU: **2012 NF PE RVU:** 0.74
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.74

RUC Recommendation: 2.00 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93464 **Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.8
2007 NF PE RVU: **2012 NF PE RVU:** 5.68
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.80 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93501 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 32,786

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93508 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 95,985

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93510 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More/ CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 799,914

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU:0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93511 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 189

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU:0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93514 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 163

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU:0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93524 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 120

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93526 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 128,459

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93527 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 2,688

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93528 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 80

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93529 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 77

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93539 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 165,924

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93540 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 171,268

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93541 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,387

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93542 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 2,871

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93543 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 830,740

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93544 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 81,056

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93545 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,023,744

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: NA **2012 NF PE RVU:**
2007 Fac PE RVU: 0 **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93555 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 823,166

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93556 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: XXX **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 998,651

2007 Work RVU: 0.00 **2012 Work RVU:**
2007 NF PE RVU: 0 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93563 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.11
2007 NF PE RVU: **2012 NF PE RVU:** 0.41
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.41

RUC Recommendation: 2.00 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93564 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.13
2007 NF PE RVU: **2012 NF PE RVU:** 0.42
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.42

RUC Recommendation: 2.10 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93565 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.86
2007 NF PE RVU: **2012 NF PE RVU:** 0.32
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.32

RUC Recommendation: 1.90 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93566 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.86
2007 NF PE RVU: **2012 NF PE RVU:** 4.34
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.31

RUC Recommendation: 0.96 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93567 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.97
2007 NF PE RVU: **2012 NF PE RVU:** 3.21
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.36

RUC Recommendation: 0.97 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93568 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.88
2007 NF PE RVU: **2012 NF PE RVU:** 3.82
2007 Fac PE RVU: **2012 Fac PE RVU:** 0.33

RUC Recommendation: 0.98 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:** 28,109

2007 Work RVU: 6.99 **2012 Work RVU:** 6.99
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 3.03 **2012 Fac PE RVU:** 2.98

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

93620 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording**

Global: 000 **Issue:** Intracardiac Catheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 54,655

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0 **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: 0 **2012 Fac PE RVU:** NA

RUC Recommendation: 11.57 **CPT Action (if applicable):** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93641 **Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator**

Global: 000 **Issue:** Insertion/Removal of Pacemaker or Pacing Carioverter-Defibillator **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2010 Medicare Utilization Data:** 77,405

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: NA **2012 NF PE RVU:** 0.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Maintain **CPT Action (if applicable):** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93651 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination**

Global: 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 37,585

2007 Work RVU: 16.23 **2012 Work RVU:** 16.23
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 6.96 **2012 Fac PE RVU:** 6.90

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93652 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia**

Global: 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** CMS Fastest Growing/Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 3,384

2007 Work RVU: 17.65 **2012 Work RVU:** 17.65
2007 NF PE RVU: NA **2012 NF PE RVU:** NA
2007 Fac PE RVU: 7.58 **2012 Fac PE RVU:** 7.53

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93653 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 15.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93654 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 20.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93655 **Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 9.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93656 **Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 20.02 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93657 **Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 10.00 **CPT Action (if applicable):** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Electrocardiography **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 12,946

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0 **2012 NF PE RVU:** 0.00
2007 Fac PE RVU:0 **2012 Fac PE RVU:**NA

RUC Recommendation: Review September 2014 **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

93701 **Bioimpedance-derived physiologic cardiovascular analysis**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 337,649

2007 Work RVU: 0.17 **2012 Work RVU:** 0
2007 NF PE RVU: 0.91 **2012 NF PE RVU:** 0.75
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

93731 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.45 **2012 Work RVU:**
2007 NF PE RVU: 0.7 **2012 NF PE RVU:**
2007 Fac PE RVU:NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93732 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.92 **2012 Work RVU:**
2007 NF PE RVU: 0.94 **2012 NF PE RVU:**
2007 Fac PE RVU:NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93733 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 0.17 **2012 Work RVU:**
2007 NF PE RVU: 0.83 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93743 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.03 **2012 Work RVU:**
2007 NF PE RVU: 1.15 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93744 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:**

2007 Work RVU: 1.18 **2012 Work RVU:**
2007 NF PE RVU: 1.19 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93875 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 107,531

2007 Work RVU: 0.22 **2012 Work RVU:**
2007 NF PE RVU: 2.38 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** SS in process of de

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Status Report: CMS Requests and Relativity Assessment Issues

93880 **Duplex scan of extracranial arteries; complete bilateral study**

Global: XXX **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,965,457

2007 Work RVU: 0.60 **2012 Work RVU:** 0.6
2007 NF PE RVU: 5.67 **2012 NF PE RVU:** 6.76
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for October 2012 RUC meeting.

CPT Action (if applicable): October 2010 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Addressed in CPT

93882 **Duplex scan of extracranial arteries; unilateral or limited study**

Global: XXX **Issue:** **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 44,012

2007 Work RVU: 0.40 **2012 Work RVU:** 0.4
2007 NF PE RVU: 3.63 **2012 NF PE RVU:** 4.79
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for October 2012 RUC meeting.

CPT Action (if applicable): **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

93886 **Transcranial Doppler study of the intracranial arteries; complete study**

Global: XXX **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 73,466

2007 Work RVU: 0.94 **2012 Work RVU:** 0.94
2007 NF PE RVU: 6.77 **2012 NF PE RVU:** 9.48
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: CCI Edits

CPT Action (if applicable): October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93888 **Transcranial Doppler study of the intracranial arteries; limited study**

Global: XXX **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 16,535

2007 Work RVU: 0.62 **2012 Work RVU:** 0.62
2007 NF PE RVU: 4.36 **2012 NF PE RVU:** 5.73
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: CCI Edits **CPT Action (if applicable):** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93922 **Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** October 2008 **2010 Medicare Utilization Data:** 611,045

2007 Work RVU: 0.25 **2012 Work RVU:** 0.25
2007 NF PE RVU: 2.78 **2012 NF PE RVU:** 2.79
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 0.25 **CPT Action (if applicable):** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93923 **Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2010 Medicare Utilization Data:** 633,077

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 4.18 **2012 NF PE RVU:** 4.24
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.45 **CPT Action (if applicable):** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93924 **Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2010 Medicare Utilization Data:** 118,590

2007 Work RVU: 0.50 **2012 Work RVU:** 0.5
2007 NF PE RVU: 5.05 **2012 NF PE RVU:** 5.42
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.50 **CPT Action (if applicable):** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93925 **Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Extremity Studies **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 35 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 586,176

2007 Work RVU: 0.58 **2012 Work RVU:** 0.58
2007 NF PE RVU: 7.05 **2012 NF PE RVU:** 8.68
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.90 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93926 **Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: **Issue:** Extremity Studies **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 35 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.70 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93931 **Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 42,105

2007 Work RVU: 0.31 **2012 Work RVU:** 0.31
2007 NF PE RVU: 3.64 **2012 NF PE RVU:** 4.60
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: CCI Edits **CPT Action (if applicable):** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93970 **Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study**

Global: XXX **Issue:** Extremity Studies **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 35 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2010 Medicare Utilization Data:** 1,599,899

2007 Work RVU: 0.68 **2012 Work RVU:** 0.68
2007 NF PE RVU: 5.44 **2012 NF PE RVU:** 6.91
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.70 **CPT Action (if applicable):** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93971 **Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study**

Global: XXX **Issue:** Extremity Study **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 29 **Specialty Developing Recommendation:** ACR, SVS **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,494,585

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 3.67 **2012 NF PE RVU:** 4.06
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.45 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93976 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study**

Global: XXX **Issue:** Vasculary Study **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2010 Medicare Utilization Data:** 119,154

2007 Work RVU: 1.21 **2012 Work RVU:** 1.21
2007 NF PE RVU: 4.33 **2012 NF PE RVU:** 5.11
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Review September 2012 **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

93990 **Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)**

Global: XXX **Issue:** Echocardiography **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** SVS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 70,446

2007 Work RVU: 0.25 **2012 Work RVU:** 0.25
2007 NF PE RVU: 4.28 **2012 NF PE RVU:** 6.06
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94010 **Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,268,372

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.69 **2012 NF PE RVU:** 0.87
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94014 **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 10,803

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 0.77 **2012 NF PE RVU:** 0.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94015 **Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 9,423

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.61 **2012 NF PE RVU:** 0.68
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94016 **Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** April 2008 **2010 Medicare Utilization Data:** 26,634

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 0.16 **2012 NF PE RVU:** 0.17
2007 Fac PE RVU: 0.16 **2012 Fac PE RVU:** 0.17

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94060 **Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 30 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,231,612

2007 Work RVU: 0.31 **2012 Work RVU:** 0.26
2007 NF PE RVU: 1.13 **2012 NF PE RVU:** 1.51
2007 Fac PE RVU: 1.13 **2012 Fac PE RVU:** NA

RUC Recommendation: 0.31 **CPT Action (if applicable):** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

94240 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 625,562

2007 Work RVU: 0.26 **2012 Work RVU:**
2007 NF PE RVU: 0.7 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94260 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 296,855

2007 Work RVU: 0.13 **2012 Work RVU:**
2007 NF PE RVU: 0.63 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94350 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 128,943

2007 Work RVU: 0.26 **2012 Work RVU:**
2007 NF PE RVU: 0.73 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94360 **Deleted from CPTDeleted from CPTDeleted from CPTDeleted from CPT** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 340,451

2007 Work RVU: 0.26 **2012 Work RVU:**
2007 NF PE RVU: 0.77 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94370 **Determination of airway closing volume, single breath tests** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 60,009

2007 Work RVU: 0.26 **2012 Work RVU:**
2007 NF PE RVU: 0.69 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94450 **Breathing response to hypoxia (hypoxia response curve)** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 880

2007 Work RVU: 0.40 **2012 Work RVU:** 0.4
2007 NF PE RVU: 0.89 **2012 NF PE RVU:** 1.46
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94681 **Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AACE, TES, ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 14,627

2007 Work RVU: 0.20 **2012 Work RVU:** 0.2
2007 NF PE RVU: 2.16 **2012 NF PE RVU:** 1.37
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94720 **Carbon monoxide diffusing capacity (eg, single breath, steady state)** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 913,333

2007 Work RVU: 0.26 **2012 Work RVU:**
2007 NF PE RVU: 1.04 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94725 **Membrane diffusion capacity** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 28,306

2007 Work RVU: 0.26 **2012 Work RVU:**
2007 NF PE RVU: 2.43 **2012 NF PE RVU:**
2007 Fac PE RVU: NA **2012 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94726 **Plethysmography for determination of lung volumes and, when performed, airway resistance** **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.26
2007 NF PE RVU: **2012 NF PE RVU:** 1.29
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.31 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

94727 **Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes** **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.26
2007 NF PE RVU: **2012 NF PE RVU:** 0.96
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.31 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94728 **Airway resistance by impulse oscillometry** **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.26
2007 NF PE RVU: **2012 NF PE RVU:** 0.96
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.31 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

94729 **Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.17
2007 NF PE RVU: **2012 NF PE RVU:** 1.38
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.19 **CPT Action (if applicable):** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

94760 **Noninvasive ear or pulse oximetry for oxygen saturation; single determination** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2010 Medicare Utilization Data:** 125,994

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.05 **2012 NF PE RVU:** 0.08
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94761 **Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2010 Medicare Utilization Data:** 16,553

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.08 **2012 NF PE RVU:** 0.13
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94762 **Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 361,461

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.56 **2012 NF PE RVU:** 0.44
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

94770 **Carbon dioxide, expired gas determination by infrared analyzer**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 29,834

2007 Work RVU: 0.15 **2012 Work RVU:** 0.15
2007 NF PE RVU: 0.76 **2012 NF PE RVU:** 0.28
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.28

RUC Recommendation: Remove office-based PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95004 **Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:** 6,975,169

2007 Work RVU: 0.00 **2012 Work RVU:** 0.01
2007 NF PE RVU: 0.12 **2012 NF PE RVU:** 0.17
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.01 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95010 **Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:** 80,259

2007 Work RVU: 0.15 **2012 Work RVU:** 0.11
2007 NF PE RVU: 0.31 **2012 NF PE RVU:** 0.24
2007 Fac PE RVU: 0.06 **2012 Fac PE RVU:** 0.04

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95015 **Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:** 56,202

2007 Work RVU: 0.15 **2012 Work RVU:** 0.06
2007 NF PE RVU: 0.16 **2012 NF PE RVU:** 0.14
2007 Fac PE RVU: 0.06 **2012 Fac PE RVU:** 0.02

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95017 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests**

Global: **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.07 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95018 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests**

Global: **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.14 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95024 **Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI, AAOA **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,600,062

2007 Work RVU: 0.00 **2012 Work RVU:** 0.01
2007 NF PE RVU: 0.17 **2012 NF PE RVU:** 0.21
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.01

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95027 **Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:** 239,371

2007 Work RVU: 0.00 **2012 Work RVU:** 0.01
2007 NF PE RVU: 0.17 **2012 NF PE RVU:** 0.13
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.01 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95115 **Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** January 2012 **2010 Medicare Utilization Data:** 1,191,083

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.35 **2012 NF PE RVU:** 0.28
2007 Fac PE RVU: 0.29 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95117 **Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,006,419

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.44 **2012 NF PE RVU:** 0.34
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95144 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2010 Medicare Utilization Data:** 218,143

2007 Work RVU: 0.06 **2012 Work RVU:** 0.06
2007 NF PE RVU: 0.21 **2012 NF PE RVU:** 0.30
2007 Fac PE RVU: 0.02 **2012 Fac PE RVU:** 0.02

RUC Recommendation: 0.06 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95148 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms**

Global: XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 15,038

2007 Work RVU: 0.06 **2012 Work RVU:** 0.06
2007 NF PE RVU: 0.67 **2012 NF PE RVU:** 1.37
2007 Fac PE RVU: 0.03 **2012 Fac PE RVU:** 0.02

RUC Recommendation: 0.06 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95165 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 5,448,102

2007 Work RVU: 0.06 **2012 Work RVU:** 0.06
2007 NF PE RVU: 0.21 **2012 NF PE RVU:** 0.31
2007 Fac PE RVU: 0.02 **2012 Fac PE RVU:** 0.03

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95800 **Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.05
2007 NF PE RVU: **2012 NF PE RVU:** 3.63
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.05 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95801 **Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1
2007 NF PE RVU: **2012 NF PE RVU:** 1.49
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 1.00 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95803 **Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** NA **2010 Medicare Utilization Data:** 257

2007 Work RVU: **2012 Work RVU:** 0.9
2007 NF PE RVU: **2012 NF PE RVU:** 3.91
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.90 and New PE inputs **CPT Action (if applicable):** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95805 **Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:** 7,559

2007 Work RVU: 1.88 **2012 Work RVU:** 1.2
2007 NF PE RVU: 14.7 **2012 NF PE RVU:** 10.99
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.20 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95806 **Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:** 8,205

2007 Work RVU: 1.66 **2012 Work RVU:** 1.25
2007 NF PE RVU: 3.46 **2012 NF PE RVU:** 4.07
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 1.28 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95807 **Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:** 2,655

2007 Work RVU: 1.66 **2012 Work RVU:** 1.28
2007 NF PE RVU: 11.82 **2012 NF PE RVU:** 13.21
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 1.25 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95808 **Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:** 911

2007 Work RVU: 2.65 **2012 Work RVU:** 1.74
2007 NF PE RVU: 13.79 **2012 NF PE RVU:** 17.82
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 1.74 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95810 **Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:** 311,700

2007 Work RVU: 3.52 **2012 Work RVU:** 2.5
2007 NF PE RVU: 17.54 **2012 NF PE RVU:** 16.76
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: 2.50 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95811 **Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2010 Medicare Utilization Data:** 330,732

2007 Work RVU: 3.79 **2012 Work RVU:** 2.6
2007 NF PE RVU: 19.32 **2012 NF PE RVU:** 17.93
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 2.60 **CPT Action (if applicable):** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95816 **Electroencephalogram (EEG); including recording awake and drowsy**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 1.08
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Survey for October 2012. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

95819 **Electroencephalogram (EEG); including recording awake and asleep**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 295,993

2007 Work RVU: 1.08 **2012 Work RVU:** 1.08
2007 NF PE RVU: 3.76 **2012 NF PE RVU:** 10.09
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for October 2012. **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95822 **Electroencephalogram (EEG); recording in coma or sleep only** **Global:** XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 19,815

2007 Work RVU: 1.08 **2012 Work RVU:** 1.08
2007 NF PE RVU: 4.82 **2012 NF PE RVU:** 9.10
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for October 2012. **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

95860 **Needle electromyography; 1 extremity with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 262,621

2007 Work RVU: 0.96 **2012 Work RVU:** 0.96
2007 NF PE RVU: 1.36 **2012 NF PE RVU:** 1.82
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.96 **CPT Action (if applicable):** February 2011 & October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95861 **Needle electromyography; 2 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 374,908

2007 Work RVU: 1.54 **2012 Work RVU:** 1.54
2007 NF PE RVU: 1.48 **2012 NF PE RVU:** 2.50
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.54 **CPT Action (if applicable):** February 2011 & October 2011 & February 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95863 **Needle electromyography; 3 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 15,405

2007 Work RVU: 1.87 **2012 Work RVU:** 1.87
2007 NF PE RVU: 1.79 **2012 NF PE RVU:** 3.01
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.87 **CPT Action (if applicable):** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95864 **Needle electromyography; 4 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 19,335

2007 Work RVU: 1.99 **2012 Work RVU:** 1.99
2007 NF PE RVU: 2.53 **2012 NF PE RVU:** 3.30
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.99 **CPT Action (if applicable):** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95867 **Needle electromyography; cranial nerve supplied muscle(s), unilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:** 3,828

2007 Work RVU: 0.79 **2012 Work RVU:** 0.79
2007 NF PE RVU: 0.98 **2012 NF PE RVU:** 1.86
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.79 **CPT Action (if applicable):** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95868 **Needle electromyography; cranial nerve supplied muscles, bilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:** 2,586

2007 Work RVU: 1.18 **2012 Work RVU:** 1.18
2007 NF PE RVU: 1.26 **2012 NF PE RVU:** 2.37
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.18 **CPT Action (if applicable):** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95869 **Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:** 6,392

2007 Work RVU: 0.37 **2012 Work RVU:** 0.37
2007 NF PE RVU: 0.53 **2012 NF PE RVU:** 1.61
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.37 **CPT Action (if applicable):** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95870 **Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:** 70,090

2007 Work RVU: 0.37 **2012 Work RVU:** 0.37
2007 NF PE RVU: 0.53 **2012 NF PE RVU:** 1.53
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.37 **CPT Action (if applicable):** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95885 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.35
2007 NF PE RVU: **2012 NF PE RVU:** 1.27
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.35 **CPT Action (if applicable):** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95886 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.92
2007 NF PE RVU: **2012 NF PE RVU:** 1.61
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.92 **CPT Action (if applicable):** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95887 **Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.73
2007 NF PE RVU: **2012 NF PE RVU:** 1.53
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.73 **CPT Action (if applicable):** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95900 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** MPC List / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,352,877

2007 Work RVU: 0.42 **2012 Work RVU:** 0.42
2007 NF PE RVU: 1.18 **2012 NF PE RVU:** 1.45
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011& February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95903 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** September 2011 **2010 Medicare Utilization Data:** 2,108,664

2007 Work RVU: 0.60 **2012 Work RVU:** 0.6
2007 NF PE RVU: 1.15 **2012 NF PE RVU:** 1.57
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 and February 2012 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95904 **Nerve conduction, amplitude and latency/velocity study, each nerve; sensory**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More / Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 3,651,015

2007 Work RVU: 0.34 **2012 Work RVU:** 0.34
2007 NF PE RVU: 1.03 **2012 NF PE RVU:** 1.31
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** February 2011 & October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95907 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 1-2 nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.00 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95908 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 3-4 nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.37 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95909 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 5-6 nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.77 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95910 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 7-8 nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.80 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95911 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 9-10 nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 3.34 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95912 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 11-12 nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 4.00 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95913 **Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 13 or more nerve conduction studies**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 4.20 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95921 **Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** October 2009 **2010 Medicare Utilization Data:** 77,970

2007 Work RVU: 0.90 **2012 Work RVU:** 0.9
2007 NF PE RVU: 0.82 **2012 NF PE RVU:** 1.53
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.90 **CPT Action (if applicable):** February 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95922 **Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** High Volume Growth / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** February 2008 **2010 Medicare Utilization Data:** 67,156

2007 Work RVU: 0.96 **2012 Work RVU:** 0.96
2007 NF PE RVU: 1 **2012 NF PE RVU:** 2.10
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.96 **CPT Action (if applicable):** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2008

Status Report: CMS Requests and Relativity Assessment Issues

95923 **Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential**

Global: **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.90 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95924 **Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt**

Global: **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 1.86 (Interim) **CPT Action (if applicable):** February 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

95925 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 50 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 56,608

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 1.63 **2012 NF PE RVU:** 4.33
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.54 and New PE Inputs **CPT Action (if applicable):** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95926 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 50 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 60,798

2007 Work RVU: 0.54 **2012 Work RVU:** 0.54
2007 NF PE RVU: 1.59 **2012 NF PE RVU:** 4.16
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.54 and New PE Inputs **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95928 **Central motor evoked potential study (transcranial motor stimulation); upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 50 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 15,990

2007 Work RVU: 1.50 **2012 Work RVU:** 1.5
2007 NF PE RVU: 3.25 **2012 NF PE RVU:** 5.89
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.50 and New PE Inputs **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95929 **Central motor evoked potential study (transcranial motor stimulation); lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 50 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2010 Medicare Utilization Data:** 16,413

2007 Work RVU: 1.50 **2012 Work RVU:** 1.5
2007 NF PE RVU: 3.48 **2012 NF PE RVU:** 6.01
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.50 and New PE Inputs **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95934 **H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle**

Global: XXX **Issue:** **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 381,339

2007 Work RVU: 0.51 **2012 Work RVU:** 0.51
2007 NF PE RVU: 0.55 **2012 NF PE RVU:** 1.28
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 & February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95936 **H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle**

Global: XXX **Issue:** **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 23,549

2007 Work RVU: 0.55 **2012 Work RVU:** 0.55
2007 NF PE RVU: 0.49 **2012 NF PE RVU:** 0.89
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **CPT Action (if applicable):** October 2011 & February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95938 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 50 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0.86
2007 NF PE RVU: **2012 NF PE RVU:** 7.76
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 0.86 and new PE inputs **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95939 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 50 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 2.25
2007 NF PE RVU: **2012 NF PE RVU:** 11.20
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: 2.25 and new PE inputs **CPT Action (if applicable):** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95940 **Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)**

Global: **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 0.60 **CPT Action (if applicable):** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95941 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: 2.00 **CPT Action (if applicable):** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95943 **Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change**

Global: **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More **Complete?** No

Most Recent RUC Meeting: April 2012 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:**
2007 NF PE RVU: **2012 NF PE RVU:**
2007 Fac PE RVU: **2012 Fac PE RVU:**

RUC Recommendation: Survey for October 2012 **CPT Action (if applicable):** February 2012 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

95950 **Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours**

Global: XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 26 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2010 Medicare Utilization Data:** 1,502

2007 Work RVU: 1.51 **2012 Work RVU:** 1.51
2007 NF PE RVU: 4.18 **2012 NF PE RVU:** 7.15
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.51 and new PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95953 **Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended**

Global: XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 26 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2010 Medicare Utilization Data:** 18,628

2007 Work RVU: 3.30 **2012 Work RVU:** 3.08
2007 NF PE RVU: 7.52 **2012 NF PE RVU:** 9.36
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 3.08 **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95954 **Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)**

Global: XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 1,905

2007 Work RVU: 2.45 **2012 Work RVU:** 2.45
2007 NF PE RVU: 4.38 **2012 NF PE RVU:** 9.32
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

95956 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse**

Global: XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 26 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 9,569

2007 Work RVU: 3.08 **2012 Work RVU:** 3.61
2007 NF PE RVU: 15.47 **2012 NF PE RVU:** 30.71
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 3.61. CPT Assistant article published **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Status Report: CMS Requests and Relativity Assessment Issues

95970 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming**

Global: XXX **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 17,164

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.86 **2012 NF PE RVU:** 1.38
2007 Fac PE RVU: 0.14 **2012 Fac PE RVU:** 0.19

RUC Recommendation: 0.45 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95971 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming**

Global: XXX **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR **First Identified:** October 2009 **2010 Medicare Utilization Data:** 26,356

2007 Work RVU: 0.78 **2012 Work RVU:** 0.78
2007 NF PE RVU: 0.66 **2012 NF PE RVU:** 0.84
2007 Fac PE RVU: 0.22 **2012 Fac PE RVU:** 0.32

RUC Recommendation: 0.78 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95972 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour**

Global: XXX **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 57,891

2007 Work RVU: 1.50 **2012 Work RVU:** 1.5
2007 NF PE RVU: 1.21 **2012 NF PE RVU:** 1.54
2007 Fac PE RVU: 0.48 **2012 Fac PE RVU:** 0.64

RUC Recommendation: 1.50 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95973 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,286

2007 Work RVU: 0.92 **2012 Work RVU:** 0.92
2007 NF PE RVU: 0.61 **2012 NF PE RVU:** 0.82
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.41

RUC Recommendation: 0.92 **CPT Action (if applicable):** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95990 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2010 Medicare Utilization Data:** 52,301

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 1.53 **2012 NF PE RVU:** 2.49
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.00 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95991 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth / Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2010 Medicare Utilization Data:** 88,496

2007 Work RVU: 0.77 **2012 Work RVU:** 0.77
2007 NF PE RVU: 1.53 **2012 NF PE RVU:** 2.60
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.32

RUC Recommendation: 0.77 **CPT Action (if applicable):** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96105 **Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour**

Global: XXX **Issue:** Assessment of Aphasia **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 33 **Specialty Developing Recommendation:** ASHA, AAN **First Identified:** **2010 Medicare Utilization Data:** 223

2007 Work RVU: 0.00 **2012 Work RVU:** 1.75
2007 NF PE RVU: 1.83 **2012 NF PE RVU:** 1.20
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 1.75 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96365 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,448,200

2007 Work RVU: **2012 Work RVU:** 0.21
2007 NF PE RVU: **2012 NF PE RVU:** 1.89
2007 Fac PE RVU: **2012 Fac PE RVU:** NA
Result:

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

96366 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: **2010 Medicare Utilization Data:** 724,805

2007 Work RVU: **2012 Work RVU:** 0.18
2007 NF PE RVU: **2012 NF PE RVU:** 0.44
2007 Fac PE RVU: **2012 Fac PE RVU:** NA
Result:

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

96367 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 2,148,456

2007 Work RVU: **2012 Work RVU:** 0.19
2007 NF PE RVU: **2012 NF PE RVU:** 0.75
2007 Fac PE RVU: **2012 Fac PE RVU:** NA
Result:

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable):

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96368 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** **2010 Medicare Utilization Data:** 217,424

2007 Work RVU: **2012 Work RVU:** 0.17
2007 NF PE RVU: **2012 NF PE RVU:** 0.38
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

96405 **Chemotherapy administration; intralesional, up to and including 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2010 Medicare Utilization Data:** 1,709

2007 Work RVU: 0.52 **2012 Work RVU:** 0.52
2007 NF PE RVU: 2.71 **2012 NF PE RVU:** 1.94
2007 Fac PE RVU: 0.24 **2012 Fac PE RVU:** 0.34

RUC Recommendation: New PE inputs

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96406 **Chemotherapy administration; intralesional, more than 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2010 Medicare Utilization Data:** 183

2007 Work RVU: 0.80 **2012 Work RVU:** 0.8
2007 NF PE RVU: 3.08 **2012 NF PE RVU:** 2.71
2007 Fac PE RVU: 0.29 **2012 Fac PE RVU:** 0.46

RUC Recommendation: New PE inputs

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96413 **Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2010 Medicare Utilization Data:** 2,289,174

2007 Work RVU: 0.28 **2012 Work RVU:** 0.28
2007 NF PE RVU: 4.05 **2012 NF PE RVU:** 3.74
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting. New PE inputs

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96415 **Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 1,398,314

2007 Work RVU: 0.19 **2012 Work RVU:** 0.19
2007 NF PE RVU: 0.74 **2012 NF PE RVU:** 0.70
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

96416 **Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 20 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2010 Medicare Utilization Data:** 119,602

2007 Work RVU: 0.21 **2012 Work RVU:** 0.21
2007 NF PE RVU: 4.47 **2012 NF PE RVU:** 3.78
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96417 **Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2010 Medicare Utilization Data:** 634,356

2007 Work RVU: 0.21 **2012 Work RVU:** 0.21
2007 NF PE RVU: 1.89 **2012 NF PE RVU:** 1.85
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Survey for work and PE for the January 2013 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

96440 **Chemotherapy administration into pleural cavity, requiring and including thoracentesis**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** **First Identified:** NA **2010 Medicare Utilization Data:** 64

2007 Work RVU: 2.37 **2012 Work RVU:** 2.37
2007 NF PE RVU: 7.48 **2012 NF PE RVU:** 21.40
2007 Fac PE RVU: 1.17 **2012 Fac PE RVU:** 1.24

RUC Recommendation: New PE inputs

CPT Action (if applicable):

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96567 **Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session**

Global: XXX **Issue:** Photodynamic Therapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2010 Medicare Utilization Data:** 74,922

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 2.4 **2012 NF PE RVU:** 4.00
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96920 **Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm** **Global:** 000 **Issue:** Laser Treatment – Skin **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2010 Medicare Utilization Data:** 46,873

2007 Work RVU: 1.15 **2012 Work RVU:** 1.15
2007 NF PE RVU: 2.8 **2012 NF PE RVU:** 3.96
2007 Fac PE RVU:0.57 **2012 Fac PE RVU:**0.77

RUC Recommendation: 1.15 and develop CPT Assistant article.

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

96921 **Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm** **Global:** 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2010 Medicare Utilization Data:** 14,562

2007 Work RVU: 1.17 **2012 Work RVU:** 1.17
2007 NF PE RVU: 2.82 **2012 NF PE RVU:** 4.02
2007 Fac PE RVU:0.57 **2012 Fac PE RVU:**0.76

RUC Recommendation: 1.30 and develop CPT Assistant article.

CPT Action (if applicable):

Result: Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

96922 **Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm** **Global:** 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2010 Medicare Utilization Data:** 8,904

2007 Work RVU: 2.10 **2012 Work RVU:** 2.1
2007 NF PE RVU: 3.77 **2012 NF PE RVU:** 5.19
2007 Fac PE RVU:0.73 **2012 Fac PE RVU:**1.36

RUC Recommendation: 2.10 and develop CPT Assistant article.

CPT Action (if applicable):

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

97001 **Physical therapy evaluation** **Global:** XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 1,919,502

2007 Work RVU: 1.20 **2012 Work RVU:** 1.2
2007 NF PE RVU: 0.73 **2012 NF PE RVU:** 0.91
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Refer to CPT

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97016 **Application of a modality to 1 or more areas; vasopneumatic devices** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Therapeutic Procedures **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AOTA, APTA, AAPM&R **First Identified:** February 2010 **2010 Medicare Utilization Data:** 268,855

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.2 **2012 NF PE RVU:** 0.35
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Maintain **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97018 **Application of a modality to 1 or more areas; paraffin bath** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Therapeutic Procedures **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AOTA, APTA, AAPM&R **First Identified:** February 2010 **2010 Medicare Utilization Data:** 129,301

2007 Work RVU: 0.06 **2012 Work RVU:** 0.06
2007 NF PE RVU: 0.12 **2012 NF PE RVU:** 0.23
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Maintain **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97035 **Application of a modality to 1 or more areas; ultrasound, each 15 minutes** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 4,167,552

2007 Work RVU: 0.21 **2012 Work RVU:** 0.21
2007 NF PE RVU: 0.1 **2012 NF PE RVU:** 0.14
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97110 **Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Therapeutic Procedures **Screen:** Codes Reported Together 75% or More / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AOTA, APTA, AAPM&R **First Identified:** February 2010 **2010 Medicare Utilization Data:** 41,384,918

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.28 **2012 NF PE RVU:** 0.44
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Maintain **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97112 **Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 6,652,138

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.32 **2012 NF PE RVU:** 0.48
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

97116 **Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Therapeutic Procedures **Screen:** Codes Reported Together 75% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AOTA, APTA, AAPM&R **First Identified:** February 2010 **2010 Medicare Utilization Data:** 1,491,816

2007 Work RVU: 0.40 **2012 Work RVU:** 0.4
2007 NF PE RVU: 0.25 **2012 NF PE RVU:** 0.39
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.40 **CPT Action (if applicable):** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97140 **Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 17,327,960

2007 Work RVU: 0.43 **2012 Work RVU:** 0.43
2007 NF PE RVU: 0.26 **2012 NF PE RVU:** 0.40
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

97150 **Therapeutic procedure(s), group (2 or more individuals)**

Global: XXX **Issue:** Group Therapeutic Procedure **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 32 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2011 **2010 Medicare Utilization Data:** 674,472

2007 Work RVU: 0.27 **2012 Work RVU:** 0.27
2007 NF PE RVU: 0.19 **2012 NF PE RVU:** 0.30
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: 0.29 **CPT Action (if applicable):** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97530 **Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes**

Global: XXX **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2010 Medicare Utilization Data:** 6,771,927

2007 Work RVU: 0.44 **2012 Work RVU:** 0.44
2007 NF PE RVU: 0.34 **2012 NF PE RVU:** 0.54
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT **CPT Action (if applicable):** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97597 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 04 **Specialty Developing Recommendation:** APTA, APMA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 244,601

2007 Work RVU: 0.58 **2012 Work RVU:** 0.51
2007 NF PE RVU: 0.77 **2012 NF PE RVU:** 1.65
2007 Fac PE RVU:0.53 **2012 Fac PE RVU:**0.14

RUC Recommendation: 0.54 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

97598 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 04 **Specialty Developing Recommendation:** APTA, APMA **First Identified:** September 2007 **2010 Medicare Utilization Data:** 29,984

2007 Work RVU: 0.80 **2012 Work RVU:** 0.24
2007 NF PE RVU: 0.91 **2012 NF PE RVU:** 0.46
2007 Fac PE RVU:0.64 **2012 Fac PE RVU:**0.06

RUC Recommendation: 0.40 **CPT Action (if applicable):** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

97755 **Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes**

Global: XXX **Issue:** Assistive Technology Assessment **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAPMR, APTA, AOTA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 3,353

2007 Work RVU: 0.62 **2012 Work RVU:** 0.62
2007 NF PE RVU: 0.28 **2012 NF PE RVU:** 0.38
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97802 **Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2010 Medicare Utilization Data:** 191,079

2007 Work RVU: 0.45 **2012 Work RVU:** 0.53
2007 NF PE RVU: 0.39 **2012 NF PE RVU:** 0.44
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** 0.37

RUC Recommendation: 0.53 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97803 **Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2010 Medicare Utilization Data:** 125,356

2007 Work RVU: 0.37 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.38 **2012 NF PE RVU:** 0.39
2007 Fac PE RVU: 0.38 **2012 Fac PE RVU:** 0.32

RUC Recommendation: 0.45 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98925 **Osteopathic manipulative treatment (OMT); 1-2 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 75,778

2007 Work RVU: 0.45 **2012 Work RVU:** 0.46
2007 NF PE RVU: 0.31 **2012 NF PE RVU:** 0.41
2007 Fac PE RVU: 0.14 **2012 Fac PE RVU:** 0.19

RUC Recommendation: 0.50 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98926 **Osteopathic manipulative treatment (OMT); 3-4 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 120,765

2007 Work RVU: 0.65 **2012 Work RVU:** 0.71
2007 NF PE RVU: 0.4 **2012 NF PE RVU:** 0.54
2007 Fac PE RVU: 0.23 **2012 Fac PE RVU:** 0.28

RUC Recommendation: 0.75 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98927 **Osteopathic manipulative treatment (OMT); 5-6 body regions involved** **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2010 Medicare Utilization Data:** 106,373

2007 Work RVU: 0.87 **2012 Work RVU:** 0.96
2007 NF PE RVU: 0.49 **2012 NF PE RVU:** 0.68
2007 Fac PE RVU: 0.28 **2012 Fac PE RVU:** 0.35

RUC Recommendation: 1.00 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98928 **Osteopathic manipulative treatment (OMT); 7-8 body regions involved** **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 90,831

2007 Work RVU: 1.03 **2012 Work RVU:** 1.21
2007 NF PE RVU: 0.57 **2012 NF PE RVU:** 0.79
2007 Fac PE RVU: 0.32 **2012 Fac PE RVU:** 0.44

RUC Recommendation: 1.25 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98929 **Osteopathic manipulative treatment (OMT); 9-10 body regions involved** **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2010 Medicare Utilization Data:** 56,303

2007 Work RVU: 1.19 **2012 Work RVU:** 1.46
2007 NF PE RVU: 0.65 **2012 NF PE RVU:** 0.91
2007 Fac PE RVU: 0.35 **2012 Fac PE RVU:** 0.50

RUC Recommendation: 1.50 **CPT Action (if applicable):** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98940 **Chiropractic manipulative treatment (CMT); spinal, 1-2 regions** **Global:** 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 6,498,682

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.23 **2012 NF PE RVU:** 0.30
2007 Fac PE RVU: 0.12 **2012 Fac PE RVU:** 0.15

RUC Recommendation: Survey for work and PE for October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

98941 **Chiropractic manipulative treatment (CMT); spinal, 3-4 regions** **Global:** 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 14,461,065

2007 Work RVU: 0.65 **2012 Work RVU:** 0.65
2007 NF PE RVU: 0.29 **2012 NF PE RVU:** 0.38
2007 Fac PE RVU: 0.17 **2012 Fac PE RVU:** 0.22

RUC Recommendation: Survey for work and PE for October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

98942 **Chiropractic manipulative treatment (CMT); spinal, 5 regions** **Global:** 000 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2010 Medicare Utilization Data:** 1,823,194

2007 Work RVU: 0.87 **2012 Work RVU:** 0.87
2007 NF PE RVU: 0.36 **2012 NF PE RVU:** 0.45
2007 Fac PE RVU: 0.23 **2012 Fac PE RVU:** 0.29

RUC Recommendation: Survey for work and PE for October 2012 RUC meeting.

CPT Action (if applicable):

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99174 **Ocular photoscreening with interpretation and report, bilateral** **Global:** XXX **Issue:** Ocular photoscreening **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 54 **Specialty Developing Recommendation:** AAP, AAO **First Identified:** NA **2010 Medicare Utilization Data:**

2007 Work RVU: **2012 Work RVU:** 0
2007 NF PE RVU: **2012 NF PE RVU:** 0.84
2007 Fac PE RVU: **2012 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action (if applicable):** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0101 **Cervical or vaginal cancer screening; pelvic and clinical breast examination** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 1,068,524

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.51 **2012 NF PE RVU:** 0.62
2007 Fac PE RVU: NA **2012 Fac PE RVU:** 0.32

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0127 **Trimming of dystrophic nails, any number** **Global:** 000 **Issue:** **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** APMA **First Identified:** April 2011 **2010 Medicare Utilization Data:** 746,346

2007 Work RVU: 0.17 **2012 Work RVU:** 0.17
2007 NF PE RVU: 0.28 **2012 NF PE RVU:** 0.47
2007 Fac PE RVU: 0.07 **2012 Fac PE RVU:** 0.05

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0179 **Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAFP, ACP, AAHCP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,466,725

2007 Work RVU: 0.45 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.89 **2012 NF PE RVU:** 0.72
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0180 **Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAFP, ACP, AAHCP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 1,467,831

2007 Work RVU: 0.67 **2012 Work RVU:** 0.67
2007 NF PE RVU: 1.09 **2012 NF PE RVU:** 0.84
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0181 **Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAFP, ACP **First Identified:** October 2008 **2010 Medicare Utilization Data:** 428,811

2007 Work RVU: 1.73 **2012 Work RVU:** 1.73
2007 NF PE RVU: 1.32 **2012 NF PE RVU:** 1.25
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0202 **Screening mammography, producing direct digital image, bilateral, all views** **Global:** XXX **Issue:** Digital Mammography **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 4,616,796

2007 Work RVU: 0.70 **2012 Work RVU:** 0.7
2007 NF PE RVU: 2.74 **2012 NF PE RVU:** 3.36
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):**

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0204 **Diagnostic mammography, producing direct digital image, bilateral, all views** **Global:** XXX **Issue:** Digital Mammography **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 592,274

2007 Work RVU: 0.87 **2012 Work RVU:** 0.87
2007 NF PE RVU: 2.87 **2012 NF PE RVU:** 4.03
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):**

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0206 **Diagnostic mammography, producing direct digital image, unilateral, all views** **Global:** XXX **Issue:** Digital Mammography **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2010 Medicare Utilization Data:** 722,976

2007 Work RVU: 0.70 **2012 Work RVU:** 0.7
2007 NF PE RVU: 2.31 **2012 NF PE RVU:** 3.17
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):**

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0237 **Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)** **Global:** XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 148,539

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.41 **2012 NF PE RVU:** 0.29
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action (if applicable):**

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0238 **Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2010 Medicare Utilization Data:** 179,669

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 0.43 **2012 NF PE RVU:** 0.31
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0249 **Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 407,880

2007 Work RVU: 0.00 **2012 Work RVU:** 0
2007 NF PE RVU: 3.57 **2012 NF PE RVU:** 3.36
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0250 **Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2010 Medicare Utilization Data:** 150,210

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.07 **2012 NF PE RVU:** 0.08
2007 Fac PE RVU: NA **2012 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

CPT Action (if applicable):

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0268 **Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing**

Global: 000 **Issue:** Removal of Wax **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2010 Medicare Utilization Data:** 113,793

2007 Work RVU: 0.61 **2012 Work RVU:** 0.61
2007 NF PE RVU: 0.63 **2012 NF PE RVU:** 0.89
2007 Fac PE RVU:0.23 **2012 Fac PE RVU:**0.31

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0270 **Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ADA **First Identified:** February 2008 **2010 Medicare Utilization Data:** 11,407

2007 Work RVU: 0.37 **2012 Work RVU:** 0.45
2007 NF PE RVU: 0.38 **2012 NF PE RVU:** 0.39
2007 Fac PE RVU:0.38 **2012 Fac PE RVU:**0.32

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0283 **Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2010 Medicare Utilization Data:** 6,269,648

2007 Work RVU: 0.18 **2012 Work RVU:** 0.18
2007 NF PE RVU: 0.12 **2012 NF PE RVU:** 0.20
2007 Fac PE RVU:NA **2012 Fac PE RVU:**NA

RUC Recommendation: Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Specialty and Acronym

Society	Acronym
AMA CPT Editorial Panel	AMA
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians & Investigators	AAPPI
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS

Society	Acronym
American College of Cardiology	ACC
American College of Chest Physicians	ACCP
American College of Emergency Physicians	ACEP
American College of Medical Genetics	ACMG
American College of Obstetricians and Gynecologists	ACOG
American College of Occupational and Environmental Medicine	ACOEM
American College of Physicians	ACP
American College of Preventive Medicine	ACPM
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Dietetic Association	ADiA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Institute of Ultrasound in Medicine	AIUM
American Medical Association	AMA
American Medical Directors Association	AMDA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Association	AOA-Ortho
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Roentgen Ray Society	ARRS

Society	Acronym
American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
American Society of Cytopathology	ASC
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Maxillofacial Surgeons	ASMS
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Ophthalmic Plastic and Reconstructive	ASOPRS
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP

Society	Acronym
Congress of Neurological Surgeons	CNS
Contact Lens Society of America	CLSA
Infectious Diseases Society of America	IDSA
International Spinal Injection Society	ISIS
International Spine Intervention Society	ISIS
Joint Council of Allergy Asthma and Immunology	JCAAI
Joint Council of Allergy, Asthma and Immunology	JCAAI
Medical Group Management Association	MGMA
MedPAC	MedPAC
National Association of Social Workers	NASW
North American Spine Society	NASS
Practice Expense Review Committee (PERC)	PERC
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine	SNM
Society of Thoracic Surgeons	STS
The Endocrine Society	TES
The Triological Society	TTS

RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
16030	**Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)**	Different Performing Specialty from Survey	April 2010	CPT Assistant article	ACEP, ASPS, AAFP, AAPMR, ACS, AAP	Under development by CPT staff (expected publication by Nov 2012).

Background: This service was brought forward as part of the family of 16020 and 16025. April 2010, refer to CPT Assistant for site-of-service clarification.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
26080	**Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each**	Site of Service Anomaly	October 2009	CPT Assistant Article and Re-review October 2012.	ASSH, AAOS	

Background: A majority of these services are performed in the out-patient hospital setting, though the survey respondents overwhelmingly state that the service is always performed as an in-patient procedure. The only variance among respondents was the length of stay which was estimated to be between one and six days. Based on these differences, the specialty society concluded and the RUC agreed that there is no appropriate typical patient for the code as currently described. The RUC concurred that greater granularity of the CPT descriptor is a more appropriate path.

At the Oct 2009 RUC meeting, the Workgroup reviewed this code and recommended that the SS develop a CPT Assistant article to describe the correct coding of 26080, 26070, 24000 and 23107, and the various scenarios of removal of a foreign body and incision and drainage of an infection without exploration of the joint. Workgroup recommends to review this service again after 2 years of claims data. (October 2012).

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
27370	**Injection procedure for knee arthrography**	High Volume Growth / CMS Fastest Growing	October 2009	CPT Assistant Article	AAOS, ACR	ACR clinical examples - under development

Background: The specialty commented that these codes were reviewed through the RUC's high volume growth screen and removed from the screen. The increase in utilization is due to a non-coverage decision for arthroscopic lavage. Physicians using these codes to report different procedures. In February 2009 these procedures were referred to CPT for possible deletion of 73580 and 27370 and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes. In Oct 2009, the RUC recommended that the SS develop a CPT Asst article to address misuse reporting of arthrography codes.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
64450	**Injection, anesthetic agent; other peripheral nerve or branch**	Harvard Valued - Utilization over 100,000	September 2011	0.75	ASA, AAPM, APMA, ASIPP	

Background: In CPT 2009, codes 64455 and 64632 were created and it was expected that podiatrists would frequently use these codes instead of 64450. In the February 2010, the action plan from the specialty societies indicated that a significant drop in the frequency for 64450 was to be expected. The data from 2009 and 2010 indicate that 64450 is steadily increasing as well as additional reporting of 64455 and 64632. However, the increased reporting of 64450 is primarily from primary care. A CPT Assistant article should be developed to clarify the appropriate reporting of this service.

RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
76513	**Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy**	High Volume Growth	September 2011	CPT Assistant Article and 0.66.	AAO, AOA (optometric)	SS submitted article to AMA staff 5/2/2012

Background: RUC surveyed ultrasound biomicroscopy as a new service in April 2004.The usage increased steadily as the technology diffused into the marketplace. Another technology using optical coherence tomography that provides similar results was introduced and a Category III code was created. AAO submitted to CPT parenthetical changes to note that the new service should not be billed with 76513 and instead should be reported with 0187T. A subsequent CPT Assistant article was published in Nov. 2009. The manufacturer of the optical coherence tomography obtained a category I code in 2010 that went into effect in 2011. Now that there are two distinct category 1 codes for the two different services, AAO suggested and the RUC agreed a follow-up CPT Assistant article be developed to differentiate between the new category I code and the existing code.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
76881	**Ultrasound, extremity, nonvascular, real-time with image documentation; complete**	CMS Fastest Growing	April 2010	Develop CPT Assistant article. 0.72	AAPMR, APMA, ACR	SS to develop CCP

Background: In February 2010, the CPT Editorial Panel created this code after deleting 76880. April 2010, the RUC recommended a CPT Assistant article be written to ensure the proper reporting of these two services. It was noted by the RUC that these services should not typically be reported more than once per day. In April 2012, SS indicated they will develop a CCP to address the CPT Executive Committees concerns instead of a CPT Asst article.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
76882	**Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific**	CMS Fastest Growing	April 2010	Develop CPT Assistant article. 0.50	AAPMR, APMA, ACR	SS to develop CCP

Background: In February 2010, the CPT Editorial Panel created this code after deleting 76880. April 2010, the RUC recommended a CPT Assistant article be written to ensure the proper reporting of these two services. It was noted by the RUC that these services should not typically be reported more than once per day. In April 2012, SS indicated they will develop a CCP to address the CPT Executive Committees concerns instead of a CPT Asst article.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
88365	**In situ hybridization (eg, FISH), each probe**	CMS Request - NPRM for 2012	September 2011	Review at the RAW		

Background: CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS states that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. However, the first 6 months of 2011 claims data have been shared with the RUC and CMS requests that additional review of these data be considered to determine if further action is warranted. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 8367 and 88368. The Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS. In Jan 2012, the Workgroup reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The Workgroup indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The Workgroup recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013).

RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
88367	**Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology**	CMS Request - NPRM for 2012	September 2011	Review at the RAW		

Background: CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS states that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. However, the first 6 months of 2011 claims data have been shared with the RUC and CMS requests that additional review of these data be considered to determine if further action is warranted. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 8367 and 88368. The Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS. In Jan 2012, the Workgroup reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The Workgroup indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The Workgroup recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013).

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
88368	**Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual**	CMS Request - NPRM for 2012	September 2011	Review at the RAW		

Background: CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS states that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. However, the first 6 months of 2011 claims data have been shared with the RUC and CMS requests that additional review of these data be considered to determine if further action is warranted. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 8367 and 88368. The Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS. In Jan 2012, the Workgroup reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The Workgroup indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The Workgroup recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013).

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
92287	**Special anterior segment photography with interpretation and report; with fluorescein angiography**	Harvard Valued - Utilization over 30,000	April 2012	Refer to CPT Asst.	AAO, AOA (optometric)	

Background: Added as part of 92286. The AAO indicated that apart from utilizing an image, codes 92286 and 92287 are completely different clinical indications and conditions. These services are also provided by different specialties within ophthalmology. CPT code 92286 is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow-up care of post corneal transplant patients. CPT code 92287 is rarely performed (less than 3000 in 2010) and obtaining valid survey responses would be difficult. AAO indicated that CPT code 92287 may be inadvertently being reported in lieu of CPT code 92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report since it is designates that an image was made at the same time as the angiogram. Currently, there is no increased work when that is occurring as both have the same work value. The Academy believes that coding education and publication of a CPT Assistant article may help clarify the difference between codes 92287 and 92235. The RUC recommends that the specialty society develop a CPT Assistant article to clarify the difference between CPT codes 92287 and 92235.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
13150	**Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less**	CMS Request	April 2012	AAD, AAO-HNS, ASPS	October 2012		

Background: Specialties are requesting deletion based upon the 1.0 cm or less size of this repair makes it a medically unlikely complex repair due to the small size of the repair.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
29590	**Denis-Browne splint strapping**	Harvard Valued - Utilization over 100,000	April 2012	APMA	February 2012	08	

Background: This service was identified as part of the family for code 29540 identified through the Harvard Valued – Utilization Over 100,000 screen. In April 2010, The American Podiatric Medical Association (APMA) indicated that 29590 Denis-Browne splint strapping technique is no longer used. Additionally, the survey response had a zero median performance rate for this service. APMA requested and the HCPAC agreed that code 29590 be referred to the CPT Editorial Panel for deletion. In June 2011, the CPT Editorial Panel indicated they would reach out to other specialties performing this service to confirm deleting 29590 is appropriate. In February 2012, the CPT Editorial Panel accepted a request from the specialty societies to revise CPT code 29590 Denis-Browne splint strapping (work RVU=0.76) to more accurately describe the use of the Denis-Browne bar and to differentiate this service from other currently described services. Upon specialty survey, respondents indicated that the revised 29590 descriptor was problematic in that this code now describes manipulation and cast application. According to the specialty presenters, this service is no longer provided, as the prefabricated appliance is applied without manipulation and without casting. The RUC recommends that the current value of code be maintained pending CPT Editorial Panel action to delete this code as originally proposed.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
36215	**Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family**	Codes Reported Together 75% or More	April 2010	ACC, ACR, ASNR, AUR, SIR, SVS	February 2012		

Background: The Workgroup recommends the specialties submit a code change proposal to bundle the set of codes describing unilateral renal angiography (75722 and 36245) as well as those codes describing bilateral renal angiography (75724 and 36245) for submission by the February 2011 CPT meeting. In addition, the Workgroup feels that there is duplication on work among the carotid angiography codes when various carotid angiography services are provided together and that a code change proposal describing the more typical services would be appropriate. This coding solution describing the more common service sets should be completed by the February 2012 CPT Editorial Panel Meeting. Note: 75671, 75680, 75722, 75724, 75650 have not been RUC or Harvard reviewed. Timeline: No later than the February 2012 CPT Editorial Panel meeting (carotid).

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
36216	**Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family**	Codes Reported Together 75% or More	April 2010	ACC, ACR, ASNR, AUR, SIR, SVS	February 2012		

Background: The Workgroup recommends the specialties submit a code change proposal to bundle the set of codes describing unilateral renal angiography (75722 and 36245) as well as those codes describing bilateral renal angiography (75724 and 36245) for submission by the February 2011 CPT meeting. In addition, the Workgroup feels that there is duplication on work among the carotid angiography codes when various carotid angiography services are provided together and that a code change proposal describing the more typical services would be appropriate. This coding solution describing the more common service sets should be completed by the February 2012 CPT Editorial Panel Meeting. Note: 75671, 75680, 75722, 75724, 75650 have not been RUC or Harvard reviewed. Timeline: No later than the February 2012 CPT Editorial Panel meeting (carotid).

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
36217	**Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**	Harvard Valued - Utilization over 30,000	September 2011	SVS, AUR, ACR, ASNR, SIR	February 2012		

Background: In September 2011, the specialty societies indicated that CPT code 36217 will be affected by the current carotid angiography code change proposal (CCP) currently being developed. The specialty societies requested and the RUC agreed that review of this service be deferred until the CPT Editorial Panel considers the carotid angiography CCP.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
37204	**Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck**	Codes Reported Together 75% or More	April 2010	ACC, ACR, SIR, SVS	October 2012		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
37205	**Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel**	High Volume Growth / Codes Reported Together 75% or More	April 2010	SVS, ACS, SIR, ACR, ACC	February 2013		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
37206	**Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)**	High Volume Growth	April 2010	SVS, ACS, SIR, ACR, ACC	February 2013		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
37207	**Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel**	High Volume Growth	April 2010	SVS, ACS, SIR, ACR, ACC	February 2013		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
37208	**Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)**	High Volume Growth	April 2010	SVS, ACS, SIR, ACR, ACC	February 2013		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
68040	**Expression of conjunctival follicles (eg, for trachoma)**	High Volume Growth	September 2011	AAO	February 2012		

Background: Refer to CPT Editorial Panel for deletion.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
69210	**Removal impacted cerumen (separate procedure), 1 or both ears**	CMS High Expenditure Procedural Codes	January 2012				

Background: In January 2012, the RUC referred this issue to CPT to revise "1 or both ears" so that it may be properly surveyed.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
73500	**Radiologic examination, hip, unilateral; 1 view**	CMS-Other - Utilization over 500,000	January 2012	AAOS, ACR			

Background: In Jan 2012, the specialty society requested that this service be referred to CPT to clarify the descriptors or add editorial language/parentheicals as needed.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
73550	**Radiologic examination, femur, 2 views**	CMS-Other - Utilization over 500,000	January 2012	AAOS, ACR			

Background: In Jan 2012, the specialty society requested that this service be referred to CPT to clarify the descriptors or add editorial language/parentheicals as needed.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
75894	**Transcatheter therapy, embolization, any method, radiological supervision and interpretation**	Codes Reported Together 75% or More	April 2010	ACC, ACR, SIR, SVS	October 2012		

Background: The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when this service is reported with 37201 on the same date by the same physician.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
75896	**Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation**	Codes Reported Together 75% or More	April 2012	ACR, SIR, SVS	October 2011	18	

Background: The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when this service is reported with 37201 on the same date by the same physician.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
75898	**Transurethral destruction of prostate tissue; by microwave thermotherapy**	Codes Reported Together 75% or More	April 2012	ACR, SIR, SVS	October 2011	18	

Background: The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when this service is reported with 37201 on the same date by the same physician.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
75960	**Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel**	High Volume Growth / Codes Reported Together 75% or More	April 2010	ACC, ACR, SIR, SVS	February 2013		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Timeline: Review complete no later than the February 2011 CPT Editorial Panel meeting.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
75962	**Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation**	High Volume Growth	April 2010	ACC, ACR, SIR, SVS	February 2012		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
75964	**Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)**	High Volume Growth	April 2010	ACC, ACR, SIR, SVS	February 2012		

Background: In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
77014	**Computed tomography guidance for placement of radiation therapy fields**	CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	January 2012	ASTRO, ACR			

Background: Specialty intends on revising this service may revise to include image guidance.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
77280	**Therapeutic radiology simulation-aided field setting; simple**	Harvard Valued - Utilization over 30,000	January 2012	ASTRO			

Background: ASTRO reviewed the process of care associated with the codes in this simulation family and determined it would be most appropriate to refer these codes to CPT for revision.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
77285	**Therapeutic radiology simulation-aided field setting; intermediate**	Harvard Valued - Utilization over 30,000	January 2012	ASTRO			

Background: ASTRO reviewed the process of care associated with the codes in this simulation family and determined it would be most appropriate to refer these codes to CPT for revision.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
77290	**Therapeutic radiology simulation-aided field setting; complex**	MPC List / Harvard Valued - Utilization over 30,000	January 2012	ASTRO			

Background: ASTRO reviewed the process of care associated with the codes in this simulation family and determined it would be most appropriate to refer these codes to CPT for revision.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
77295	**Therapeutic radiology simulation-aided field setting; 3-dimensional**	Harvard Valued - Utilization over 30,000	January 2012	ASTRO			

Background: ASTRO reviewed the process of care associated with the codes in this simulation family and determined it would be most appropriate to refer these codes to CPT for revision.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
77421	**Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy**	Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes	January 2012	ASTRO			

Background: In Jan 2012, the specialty indicated that it intends on bringing the IGRT family of codes (76950 and 77421) to CPT for revision.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
88112	**Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal**	CMS High Expenditure Procedural Codes	January 2012				

Background: In January 2012 the specialty requested that this service be referred to CPT for further clarification. Now that there is sufficient claims data and additional understanding of the physician work involved CAP believes further clarification is appropriate for this service.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
88342	**Immunohistochemistry (including tissue immunoperoxidase), each antibody**	CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	January 2012	CAP			

Background: In Jan 2012, the specialty society recommended that this service be referred to CPT to better define the service.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
92506	**Evaluation of speech, language, voice, communication, and/or auditory processing**	CMS Request/Speech Language Pathology Request	February 2010	ASHA	June 2012		

Background: The specialty society after reviewing the survey data for this service agreed that more than one service is being represented under this code and requests the service be referred back to the CPT Editorial Panel for further clarification. The HCPAC recommends that 92506 be referred back to the CPT Editorial Panel to clearly describe the services being performed. ASHA is considering, at panelists' recommendations, a number of individual evaluation procedure codes focusing on each component of communication (e.g., voice, fluency, phonology, pediatric receptive/expressive language, central auditory processing). ASHA is currently working on developing a new 92506 Coding Change Proposal with input from special interest groups within ASHA and with consultation from CMS officials. SS intends on submitting a CCP by the June 2012 CPT meeting.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
97001	**Physical therapy evaluation**	CMS High Expenditure Procedural Codes	January 2012				

Background: In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
97112	**Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**	CMS High Expenditure Procedural Codes	January 2012				

Background: In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT.

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
97140	**Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes**	CMS High Expenditure Procedural Codes	January 2012				

Background: In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT.

RUC Referrals to CPT Editoral Panel - Incomplete Issues

		Screen:	RUC Meeting:	Specialty Society:	CPT Meeting:	CPT Tab:	CPT Review Complete?
97530	**Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes**	CMS High Expenditure Procedural Codes	January 2012				

Background: In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT.

New, Revised, and CMS Screened Physician Time from RUC Meetings:
September 2011, January 2012, and April 2012

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	Total Time
11300	0	1	5	10	5	0	0	0	0	0	0	0	0	0	21
11301	0	1	5	15	5	0	0	0	0	0	0	0	0	0	26
11302	0	1	5	20	5	0	0	0	0	0	0	0	0	0	31
11303	0	1	5	22	5	0	0	0	0	0	0	0	0	0	33
11305	0	1	5	14	5	0	0	0	0	0	0	0	0	0	25
11306	0	1	5	18	5	0	0	0	0	0	0	0	0	0	29
11307	0	1	5	21	5	0	0	0	0	0	0	0	0	0	32
11308	0	1	5	26	5	0	0	0	0	0	0	0	0	0	37
11310	0	1	5	20	5	0	0	0	0	0	0	0	0	0	31
11311	0	1	5	25	5	0	0	0	0	0	0	0	0	0	36
11312	0	1	5	30	5	0	0	0	0	0	0	0	0	0	41
11313	0	1	5	35	5	0	0	0	0	0	0	0	0	0	46
13100	10	5	5	32	10	0	0	0	0	0	0	1	0	0	78
13101	5	5	5	45	11	0	0	0	0	0	0	1	0	0	87
13102	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
13120	14	5	5	35	10	0	0	0	0	0	0	1	0	0	85
13121	16	5	5	45	10	0	0	0	0	0	0	1	0	0	97
13122	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
13131	10	5	5	45	15	0	0	0	0	0	0	1	0	0	96
13132	15	5	5	50	15	0	0	0	0	0	0	1	0	0	106
13133	0	0	0	35	0	0	0	0	0	0	0	0	0	0	35
13151	10	5	8	45	15	0	0	0	0	0	0	1	0	0	99
13152	20	5	8	50	20	0	0	0	0	0	0	1	0	0	119
13153	0	0	0	45	0	0	0	0	0	0	0	0	0	0	45
23472	40	15	20	140	30	0	2	1	0	1	0	1	3	0	448
23473	40	15	20	180	30	0	2	1	0	1	0	1	3	0	488
23474	40	15	20	205	30	0	2	1	0	1	0	1	3	0	513
24363	40	12	20	140	30	0	2	1	0	1	0	1	3	0	445
24370	40	12	20	175	20	0	2	1	0	1	0	1	3	0	470
24371	40	12	20	210	20	0	2	1	0	1	0	1	3	0	505
31647	19	1	5	60	30	0	0	0	0	0	0	0	0	0	115
31648	19	1	5	45	30	0	0	0	0	0	0	0	0	0	100
31649	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
31651	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
31660	19	1	5	50	30	0	0	0	0	0	0	0	0	0	105
31661	19	1	5	60	30	0	0	0	0	0	0	0	0	0	115
32551	30	3	10	20	20	0	0	0	0	0	0	0	0	0	83
32554	13	1	6	20	10	0	0	0	0	0	0	0	0	0	50
32555	13	1	5	25	10	0	0	0	0	0	0	0	0	0	54
32556	19	1	5	20	15	0	0	0	0	0	0	0	0	0	60
32557	21	3	5	28	15	0	0	0	0	0	0	0	0	0	72
32701	18	1	6	60	15	0	0	0	0	0	0	0	0	0	100
33361	50	15	20	135	45	1	0	0	0	0	0	0	0	0	335
33362	50	15	20	150	45	1	0	0	0	0	0	0	0	0	350
33363	50	15	20	180	45	1	0	0	0	0	0	0	0	0	380
33364	50	15	20	180	45	1	0	0	0	0	0	0	0	0	380
33365	50	15	20	180	45	1	0	0	0	0	0	0	0	0	380
33367	0	0	0	90	0	0	0	0	0	0	0	0	0	0	90
33368	0	0	0	120	0	0	0	0	0	0	0	0	0	0	120
33369	0	0	0	160	0	0	0	0	0	0	0	0	0	0	160
33405	60	15	20	197	40	1	1	2	3	1	0	0	1	1	768
33430	60	15	20	232	40	2	1	2	3	0	1	0	2	1	913
33533	60	15	20	158	40	1	1	1	3	1	0	1	0	1	682
33990	39	1	5	60	40	0	0	0	0	0	0	0	0	0	145
33991	54	1	5	90	45	0	0	0	0	0	0	0	0	0	195
33992	24	1	5	45	30	0	0	0	0	0	0	0	0	0	105
33993	24	1	5	30	30	0	0	0	0	0	0	0	0	0	91
35475	17	4	5	43	23	0	0	0	0	0	0	0	0	0	92
35476	17	4	5	35	20	0	0	0	0	0	0	0	0	0	81
36221	40	3	5	30	40	0	0	0	0	0	0	0	0	0	118
36222	40	3	5	40	40	0	0	0	0	0	0	0	0	0	128
36223	40	3	5	45	40	0	0	0	0	0	0	0	0	0	133
36224	40	3	5	50	40	0	0	0	0	0	0	0	0	0	138
36225	40	3	5	45	40	0	0	0	0	0	0	0	0	0	133
36226	40	3	5	50	40	0	0	0	0	0	0	0	0	0	138
36227	0	0	0	15	0	0	0	0	0	0	0	0	0	0	15
36228	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
37197	33	3	5	60	20	0	0	0	0	0	0	0	0	0	121

New, Revised, and CMS Screened Physician Time from RUC Meetings:															
September 2011, January 2012, and April 2012															
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	Total Time
37211	40	3	5	60	30	0	0	0	0	0	0	0	0	0	138
37212	40	3	5	60	30	0	0	0	0	0	0	0	0	0	138
37213	33	3	5	33	25	0	0	0	0	0	0	0	0	0	99
37214	33	3	5	38	23	0	0	0	0	0	0	0	0	0	102
38240	30	0	0	60	30	0	0	0	0	0	0	0	0	0	120
38241	18	0	0	60	30	0	0	0	0	0	0	0	0	0	108
38242	30	0	0	45	30	0	0	0	0	0	0	0	0	0	105
38243	30	0	0	45	30	0	0	0	0	0	0	0	0	0	105
44705	4	0	0	20	5	0	0	0	0	0	0	0	0	0	29
47600	40	10	20	120	30	0	1	2	1	1	0	1	2	0	475
47605	40	10	20	135	30	0	1	2	1	1	0	1	2	0	490
50590	33	3	15	60	15	0	0	0	0	0.5	0	1	2	0	207
52287	7	5	10	20	20	0	0	0	0	0	0	0	0	0	62
53850	7	5	15	60	15	0	0	0	0	0	0	1	2	1	204
64612	10	0	0	10	5	0	0	0	0	0	0	1	0	0	41
64615	15	0	0	15	5	0	0	0	0	0	0	0	0	0	35
65800	12	1	5	5	5	0	0	0	0	0	0	0	0	0	28
67810	8	1	2	13	5	0	0	0	0	0	0	0	0	0	29
72040	1	0	0	3	2	0	0	0	0	0	0	0	0	0	6
72050	1	0	0	5	2	0	0	0	0	0	0	0	0	0	8
72052	1	0	0	5	2	0	0	0	0	0	0	0	0	0	8
74170	5	0	0	18	5	0	0	0	0	0	0	0	0	0	28
76830	5	0	0	10	10	0	0	0	0	0	0	0	0	0	25
76872	10	0	0	15	10	0	0	0	0	0	0	0	0	0	35
77301	0	0	0	160	35	0	0	0	0	0	0	0	0	0	195
78012	5	0	0	5	5	0	0	0	0	0	0	0	0	0	15
78013	5	0	0	10	5	0	0	0	0	0	0	0	0	0	20
78014	5	0	0	10	5	0	0	0	0	0	0	0	0	0	20
78070	5	0	0	10	5	0	0	0	0	0	0	0	0	0	20
78071	5	0	0	15	5	0	0	0	0	0	0	0	0	0	25
78072	5	0	0	20	5	0	0	0	0	0	0	0	0	0	30
81201	0	0	0	60	0	0	0	0	0	0	0	0	0	0	60
81202	0	0	0	28	0	0	0	0	0	0	0	0	0	0	28
81203	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
81235	0	0	0	20	0	0	0	0	0	0	0	0	0	0	20
81252	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
81253	0	0	0	28	0	0	0	0	0	0	0	0	0	0	28
81254	0	0	0	15	0	0	0	0	0	0	0	0	0	0	15
81321	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
81322	0	0	0	28	0	0	0	0	0	0	0	0	0	0	28
81323	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
86153	0	0	0	20	5	0	0	0	0	0	0	0	0	0	25
90791	10	0	0	60	20	0	0	0	0	0	0	0	0	0	90
90792	10	0	0	60	20	0	0	0	0	0	0	0	0	0	90
90832	5	0	0	30	10	0	0	0	0	0	0	0	0	0	45
90833	0	0	0	30	3	0	0	0	0	0	0	0	0	0	33
90834	5	0	0	45	10	0	0	0	0	0	0	0	0	0	60
90836	0	0	0	45	3	0	0	0	0	0	0	0	0	0	48
90837	5	0	0	60	10	0	0	0	0	0	0	0	0	0	75
90838	0	0	0	60	3	0	0	0	0	0	0	0	0	0	63
90845	5	0	0	50	5	0	0	0	0	0	0	0	0	0	60
90846	5	0	0	50	10	0	0	0	0	0	0	0	0	0	65
90847	5	0	0	55	10	0	0	0	0	0	0	0	0	0	70
90853	3	0	0	10	3	0	0	0	0	0	0	0	0	0	16
91112	5	0	0	40	15	0	0	0	0	0	0	0	0	0	60
92083	3	0	0	10	0	0	0	0	0	0	0	0	0	0	13
92286	5	0	0	10	0	0	0	0	0	0	0	0	0	0	15
92920	33	1	5	60	30	0	0	0	0	0	0	0	0	0	129
92921	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
92924	33	1	5	75	30	0	0	0	0	0	0	0	0	0	144
92925	0	0	0	45	0	0	0	0	0	0	0	0	0	0	45
92928	33	1	5	71	30	0	0	0	0	0	0	0	0	0	140
92929	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
92933	33	1	5	85	30	0	0	0	0	0	0	0	0	0	154
92934	0	0	0	45	0	0	0	0	0	0	0	0	0	0	45
92937	33	1	5	60	30	0	0	0	0	0	0	0	0	0	129
92938	0	0	0	60	0	0	0	0	0	0	0	0	0	0	60
92941	33	1	5	70	40	0	0	0	0	0	0	0	0	0	149

New, Revised, and CMS Screened Physician Time from RUC Meetings:															
September 2011, January 2012, and April 2012															
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	Total Time
92943	33	1	5	90	30	0	0	0	0	0	0	0	0	0	159
92944	0	0	0	60	0	0	0	0	0	0	0	0	0	0	60
93015	2	0	0	20	4	0	0	0	0	0	0	0	0	0	26
93016	2	0	0	15	2	0	0	0	0	0	0	0	0	0	19
93018	2	0	0	5	4	0	0	0	0	0	0	0	0	0	11
93653	33	1	5	180	30	0	0	0	0	0	0	0	0	0	249
93654	33	1	5	240	40	0	0	0	0	0	0	0	0	0	319
93655	0	0	0	90	0	0	0	0	0	0	0	0	0	0	90
93656	33	1	5	240	40	0	0	0	0	0	0	0	0	0	319
93657	0	0	0	90	0	0	0	0	0	0	0	0	0	0	90
93925	5	0	0	15	5	0	0	0	0	0	0	0	0	0	25
93926	5	0	0	10	5	0	0	0	0	0	0	0	0	0	20
93970	3	0	0	15	5	0	0	0	0	0	0	0	0	0	23
95017	0.56	0	0	0.74	0.56	0	0	0	0	0	0	0	0	0	1.86
95018	1.67	0	0	1.67	1.67	0	0	0	0	0	0	0	0	0	5.01
95076	7	0	0	30	5	0	0	0	0	0	0	0	0	0	42
95079	0	0	0	30	0	0	0	0	0	0	0	0	0	0	30
95782	15	0	0	45	10	0	0	0	0	0	0	0	0	0	70
95783	20	0	0	50	15	0	0	0	0	0	0	0	0	0	85
95860	10	0	0	20	10	0	0	0	0	0	0	0	0	0	40
95861	10	0	0	29	10	0	0	0	0	0	0	0	0	0	49
95863	10	0	0	40	11	0	0	0	0	0	0	0	0	0	61
95864	10	0	0	50	13.5	0	0	0	0	0	0	0	0	0	73.5
95865	10	0	0	15	6.5	0	0	0	0	0	0	0	0	0	31.5
95866	10	0	0	15	10	0	0	0	0	0	0	0	0	0	35
95867	10	0	0	15	10	0	0	0	0	0	0	0	0	0	35
95868	10	0	0	20	10	0	0	0	0	0	0	0	0	0	40
95869	10	0	0	15	10	0	0	0	0	0	0	0	0	0	35
95870	10	0	0	15	10	0	0	0	0	0	0	0	0	0	35
95907	10	0	0	15	10	0	0	0	0	0	0	0	0	0	35
95908	10	0	0	25	10	0	0	0	0	0	0	0	0	0	45
95909	10	0	0	35	11	0	0	0	0	0	0	0	0	0	56
95910	13	0	0	40	12.5	0	0	0	0	0	0	0	0	0	65.5
95911	15	0	0	50	15	0	0	0	0	0	0	0	0	0	80
95912	15	0	0	60	15	0	0	0	0	0	0	0	0	0	90
95913	15	0	0	70	20	0	0	0	0	0	0	0	0	0	105
95921	8	0	0	15	10	0	0	0	0	0	0	0	0	0	33
95922	10	0	0	20	10	0	0	0	0	0	0	0	0	0	40
95923	5	0	0	15	10	0	0	0	0	0	0	0	0	0	30
95924	10	0	0	35	15	0	0	0	0	0	0	0	0	0	60
95940	0	0	0	15	0	0	0	0	0	0	0	0	0	0	15
95941	0	0	0	60	0	0	0	0	0	0	0	0	0	0	60
99485	15	0	0	20	12	0	0	0	0	0	0	0	0	0	47
99486	0	0	0	25	0	0	0	0	0	0	0	0	0	0	25
0300XT	50	15	20	195	45	1	0	0	0	0	0	0	0	0	395

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY						NON-FAC	
		1A	1B*	2A	2B*	3	4	5	6
	Total Pre-Service Time	**20**	**25**	**25**	**39**	**51**	**63**	**7**	**23**
	CATEGORY SUBTOTALS								
A	Pre-Service Evaluation (IWPUT =0.0224)	13	19	18	33	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	5	6	5	15	20	0	5
	DETAILS								
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	5	10	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	3	5	5	5	2	3
A	Communicate with other professionals	0	1	0	3	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	1	1	0	0
A	Administer moderate sedation/observe (wait) anesthesia care	0	5	0	10	0	0	0	0
B	Perform/ supervise patient positioning	1	1	1	1	3	3	0	1
C	Administer local anesthesia	1	0	1	0	0	0	0	5
C	Observe (wait anesthesia care)	0	0	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	5	5	0	0

* Indicates packages that contain moderate sedation

1A Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)
1B* Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)
2A Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)
2B* Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)
3 Straightforward Patient/Difficult Procedure
4 Difficult Patient/Difficult Procedure
5 Procedure without sedation/anesthesia care
6 Procedure with sedation/anesthesia care

Additional Positioning Times for Spinal Surgical Procedures

SS1	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
SS2	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
SS3	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes
SS4	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes
SS5	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes

Additional Positioning Times for Spinal Injection Procedures

SI1	Anterior Neck Injection (Supine) (eg discogram)	7 Minutes
SI2	Posterior Neck Injection (Prone) (eg facet)	5 Minutes
SI3	Posterior Thoracic/Lumbar (Prone) (eg epidural)	5 Minutes
SI4	Lateral Thoracic/Lumbar (Lateral) (eg discogram)	7 Minutes

Notes:

*Roll-over cells for additional detail where available

***Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice**

*For building block IWPUT purposes whenever the procedure is on Appendix G – (Summary of CPT codes that include moderate (conscious) sedation) the IWPUT should be .0224 for the administration of moderate sedation line item because the physician is responsible for the administration of conscious sedation. If the procedure is one where conscious sedation is not inherent the same line item should have an IWPUT of .0081.

straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support additional pre-service time.

CPT	RUC Recommended PLI Crosswalk
11300	11300
11301	11301
11302	11302
11303	11303
11305	11305
11306	11306
11307	11307
11308	11308
11310	11310
11311	11311
11312	11312
11313	11313
13100	13100
13101	13101
13102	13102
13120	13120
13121	13121
13122	13122
13131	13131
13132	13132
13133	13133
13151	13151
13152	13152
13153	13153
23472	23472
23473	23472
23474	23210
24363	24363
24370	24363
24371	24363
31647	31636
31648	31638
31649	31637
31651	31637
31660	31636
31661	31638
32551	19260
32554	32421
32555	32422
32556	32422
32557	32551
32701	33468
33361	33880
33362	33880
33363	33880
33364	33880
33365	33979
33366	33979
33367	33979
33368	33979

33369	33305
33405	33405
33430	33430
33533	33533
33990	33240
33991	33240
33992	33240
33993	33240
35475	35475
35476	35476
36221	36200
36222	36216
36223	36216
36224	36217
36225	36215
36226	36217
36227	36218
36228	36218
37197	37183
37211	37184
37212	37184
37213	37184
37214	37184
38240	38240
38241	38241
38242	38242
38243	38242
44705	91065
47600	47600
47605	47605
50590	50590
52287	51715
53850	53850
64612	64612
64615	64612
65800	65800
67810	67810
72040	72040
72050	72050
72052	72052
74170	74170
76830	76830
76872	76872
77301	77301
78012	78000
78013	78010
78014	78007
78070	78070
78071	78803
78072	78452
81201	83912
81202	83912

81203	83912
81235	88182
81252	88182
81253	88182
81254	88291
81321	88182
81322	88182
81323	88182
86153	88361
90791	90846
90792	90846
90832	90846
90833	90846
90834	90846
90836	90846
90837	90846
90838	90846
90845	90845
90846	90846
90847	90847
90853	90853
91112	91110
92083	92083
92286	92286
92920	92982
92921	92984
92924	92995
92925	92995
92928	92980
92929	92981
92933	92980
92934	92981
92937	92980
92938	92981
92941	92980
92943	92980
92944	92981
93015	93015
93016	93016
93018	93018
93653	93620
93654	93620
93655	93620
93656	93620
93657	93620
93925	93925
93926	93926
93970	93970
95017	95010
95018	95010
95076	95180
95079	95180

95782	95810
95783	95811
95860	95860
95861	95861
95863	95863
95864	95864
95865	95865
95866	95866
95867	95867
95868	95868
95869	95869
95870	95870
95907	95904
95908	95904
95909	95904
95910	95904
95911	95904
95912	95904
95913	95904
95921	95923
95922	95923
95923	95923
95924	95923
95940	95920
95941	95920
99485	99471
99486	99472

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs	
Presacral								1			
23331		1354	23331	684	0.505	7.63	18.37	2	12565	5219	
23331		1354	Savings	670	0.495	7.63	0.00	2	0	5112	
23332		1009	23332	359	0.356	12.37	20.00	2	7180	4441	
23332		1009	Savings	650	0.644	12.37	0.00	2	0	8041	
23472		24415	23472	23115	0.947	22.65	22.13	2	511535	523555	
23472		24415	23473	650	0.027	22.65	25.00	2	16250	14723	
23472		24415	23474	650	0.027	22.65	27.21	2	17687	14723	
24160		295	24160	148	0.502	8.00	8.00	3	1184	1184	*
24160		295	Savings	147	0.498	4.00	0.00	3	0	588	
24363		979	24363	832	0.850	22.65	22.00	3	18304	18845	
24363		979	24370	47	0.048	22.65	23.55	3	1107	1065	
24363		979	24371	100	0.102	22.65	27.50	3	2750	2265	
Denis-Browne								4			
31899		354	31651	125	0.353	0.00	1.58	5	198	0	
31899		354	31899	229	0.647	0.00	0.00	5	0	0	
0250T	D		31647	225	1.000	0.00	4.40	5	990	0	
0251T	D	4	31648	4	1.000	0.00	4.20	5	17	0	
0252T	D	3	31649	3	1.000	0.00	2.00	5	6	0	
0276T	D	0	31660	200	1.000	0.00	4.50	6	900	0	
0277T	D	0	31661	100	1.000	0.00	5.00	6	500	0	
32551		63483	32551	53606	0.844	3.29	3.50	7	187621	176364	
32551		63483	32557	9877	0.156	3.29	3.35	7/8	33088	32495	
32421	D	100681	32554	43293	0.430	1.54	1.54	8	66671	66671	
32421	D	100681	32555	57388	0.570	1.54	2.21	8	126827	88378	
32422	D	123629	32555	86540	0.700	2.19	2.21	8	191253	189523	
32422	D	123629	32556	37089	0.300	2.19	2.19	8	81225	81225	
76942		1261256	Savings	143928	0.114	0.67	0	8	0	96432	
76942		1261256	76942	1117328	0.886	0.67	0.67	8	748610	748610	
75989		74836	Savings	9877	0.132	1.19	0	8	0	11754	
75989		74836	75989	64959	0.868	1.19	1.19	8	77301	77301	
77002		220148	Savings	1300	0.006	0.54	0	8	0	702	
77002		220148	77002	218848	0.994	0.54	0.54	8	118178	118178	
77012		204743	Savings	10099	0.049	1.16	0	8	0	11715	
77012		204743	77012	194644	0.951	1.16	1.16	8	225787	225787	
0256T	D	627	33361	188	0.300	0.00	29.50	9	5546	0	
0256T	D	627	33362	357	0.569	0.00	32.00	9	11424	0	

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
0256T	D	627	33363	63	0.100	0.00	33.00	9	2079	0
0256T	D	627	33364	19	0.030	0.00	34.87	9	663	0
0257T	D	351	33365	102	0.291	0.00	37.50	9	3825	0
0258T	D	118	33365	35	0.297	0.00	37.50	9	1313	0
0257T	D	351	0300XT	249	0.709	0.00	40.00	9	9960	0
0258T	D	118	0300XT	83	0.703	0.00	40.00	9	3320	0
0259T	D	16	33367	5	0.313	0.00	11.88	9	59	0
0259T	D	16	33368	5	0.313	0.00	14.39	9	72	0
0259T	D	16	33369	6	0.375	0.00	19.00	9	114	0
32999		1228	32701	37	0.030	0.00	4.18	10	155	0
32999		1228	32999	1191	0.970	0.00	0.00	10	0	0
0048T	D	59	33990	50	0.847	0.00	8.15	11	408	0
0048T	D	59	33991	9	0.153	0.00	11.88	11	107	0
0050T	D	11	33992	5	0.455	0.00	4.00	11	20	0
0050T	D	11	33993	6	0.545	0.00	4.17	11	25	0
36200		84528	36200	81992	0.970	3.02	3.02	12	247616	247616
36200		84528	36221	2536	0.030	3.02	4.51	12	11437	7659
36215		79038	36222	3748	0.047	4.67	6.00	12	22488	17503
36215		79038	36222	12147	0.154	2.34	3.00	12	36441	28363
36215		79038	36223	30000	0.380	4.67	6.50	12	195000	140100
36215		79038	36223	9334	0.118	2.34	3.25	12	30336	21795
36215		79038	36225	16625	0.210	4.67	6.50	12	108063	77639
36215		79038	36215	7184	0.091	4.67	4.67	12	33549	33549
36216		61979	36222	12147	0.196	5.27	6.00	12	72882	64015
36216		61979	36223	12147	0.196	5.27	6.50	12	78956	64015
36216		61979	36224	9334	0.151	5.27	7.55	12	70472	49190
36216		61979	36224	16625	0.268	2.64	3.78	12	62759	43807
36216		61979	36226	3889	0.063	5.27	7.55	12	29362	20495
36216		61979	36227	2422	0.039	5.27	2.32	12	5619	12764
36216		61979	36216	5415	0.087	5.27	5.27	12	28537	28537
36217		30078	36224	12147	0.404	6.29	3.18	12	38627	76405
36217		30078	36226	8500	0.283	6.29	7.55	12	64175	53465
36217		30078	36227	4650	0.155	6.29	2.32	12	10788	29249
36218		24214	36227	10000	0.413	1.01	2.32	12	23200	10100
36218		24214	36228	12000	0.496	1.01	4.25	12	51000	12120
75650	D	32018	Savings	32018	1.000	1.49	0.00	12	0	47707
75665	D	11173	Savings	11173	1.000	1.31	0.00	12	0	14637
75671	D	33250	Savings	33250	1.000	1.66	0.00	12	0	55195

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs	
75676	D	11245	Savings	11245	1.000	1.31	0.00	12	0	14731	
75680	D	36443	Savings	36443	1.000	1.66	0.00	12	0	60495	
75685	D	42389	Savings	42389	1.000	1.31	0.00	12	0	55530	
75660	D	2422	Savings	2422	1.000	1.31	0.00	12	0	3173	
75662	D	4650	Savings	4650	1.000	1.66	0.00	12	0	7719	
75774		97362	Savings	12000	0.123	0.36	0.00	12	0	4320	
75774		97362	75774	85362	0.877	0.36	0.36	12	30730	30730	
37201	D	13436	37211	8062	0.600	4.99	8.00	13	64496	40229	
37201	D	13436	37212	5374	0.400	4.99	7.06	13	37940	26816	
37209	D	2650	37213	2230	0.842	2.27	5.00	13	11150	5062	
37209	D	2650	Savings	420	0.158	2.27	0.00	13	0	953	
75900	D	2230	Savings	2230	1.000	0.49	0.00	13	0	1093	
75898		46825	37214	13436	0.287	1.65	3.04	13	40845	22169	
75898		46825	Savings	16086	0.344	1.65	0.00	13	0	26542	
75898		46825	75989	17303	0.370	1.65	CP	13		28550	
75896		18190	Savings	13436	0.739	1.31	0.00	13	0	17601	
75896		18190	75896	4754	0.261	1.31	CP	13		6228	
99232		50265346	Savings	13436	0.000	1.39	0.00	13	0	18676	
99232		50265346	99232	50251910	1.000	1.39	1.39	13	69850155	69850155	
99233		21650554	Savings	16086	0.001	2.00	0.00	13	0	32172	
99233		21650554	99233	21634468	0.999	2.00	2.00	13	43268936	43268936	
37203	D	4214	37193	3582	0.850	5.02	8.00	14	28656	17982	*
37203	D	4214	37197	632	0.150	5.02	6.72	14	4247	3173	
75961	D	4324	Savings	4324	1.000	4.24	0.00	14	0	18334	
38240		377	38240	377	1.000	2.24	3.50	15	1320	844	
38241		1394	38241	1394	1.000	2.24	3.00	15	4182	3123	
38242		70	38243	4	0.057	2.24	2.13	15	9	9	
38242		70	38242	66	0.943	1.71	2.11	15	139	113	
optical								16			
44799		1295	44799	700	0.541	0.00	0.00	17	0	0	
44799		1295	44705	595	0.459	0.00	1.42	17	845	0	
53899		1649	52287	495	0.300	0.00	3.02	18	1495	0	
53899		1649	53899	1154	0.700	0.00	0.00	18	0	0	
64612		98815	64612	86957	0.880	2.01	1.41	19	122609	174784	
64612		98815	64615	11858	0.120	2.01	1.85	19	21937	23835	
64613		67695	64613	65326	0.965	2.01	2.01	19	131305	131305	
64613		67695	Savings	2369	0.035	2.01	0.00	19	0	4762	
64614		59575	64614	59575	1.000	2.20	2.20	19	131065	131065	

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CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
64999		8278	64615	500	0.060	0.00	1.85	19	925	0
64999		8278	64999	7778	0.940	0.00	0.00	19	0	0
65800		2783	65800	2783	1.000	1.91	1.53	20	4258	5316
65805	D	36275	65800	36275	1.000	1.91	1.53	20	55501	69285
67810		50,277	67810	50,277	1.000	1.48	1.18	21	59327	74410
72040		571186	72040	571186	1.000	0.22	0.22	22	125661	125661
72050		454961	72050	454961	1.000	0.31	0.31	22	141038	141038
72052		96026	72052	96026	1.000	0.36	0.36	22	34569	34569
78000	D	1402	78012	1402	1.000	0.19	0.19	23	266	266
78001	D	1130	78012	1130	1.000	0.26	0.19	23	215	294
78003	D	19	78012	19	1.000	0.33	0.19	23	4	6
78010	D	6404	78013	6404	1.000	0.39	0.37	23	2369	2498
78011	D	188	78013	188	1.000	0.45	0.37	23	70	85
78006	D	20307	78014	20307	1.000	0.49	0.50	23	10154	9950
78007	D	29384	78014	29384	1.000	0.5	0.50	23	14692	14692
78070		27900	78070	23157	0.830	0.8	0.8	24	18526	18526
78070		27900	78071	4743	0.170	0.82	1.20	24	5692	3889
78803		14173	78803	9430	0.665	1.09	1.20	24	11316	10279
78803		14173	Savings	4743	0.335	1.09	0.00	24	0	5170
78999		319	78999	159	0.498	0.00	0.00	24	0	0
78999		319	78072	160	0.502	0.00	1.60	24	256	0
78099		8	78099	4	0.500	0.00	0.00	24	0	0
78099		8	78072	4	0.500	0.00	1.60	24	6	0
83912		196140	81201	450	0.002	0.37	1.40	25	630	167
83912		196140	81202	90	0.000	0.37	0.77	25	69	33
83912		196140	81203	450	0.002	0.37	0.80	25	360	167
83912		196140	81235	10000	0.051	0.37	0.51	26	5100	3700
83912		196140	81252	400	0.002	0.37	0.65	26	260	148
83912		196140	81253	150	0.001	0.37	0.52	26	78	56
83912		196140	81254	500	0.003	0.37	0.40	26	200	185
83912		196140	81321	1000	0.005	0.37	0.80	26	800	370
83912		196140	81322	150	0.001	0.37	0.52	26	78	56
83912		196140	81323	200	0.001	0.37	0.65	26	130	74
83912		196140	83912	182750	0.932	0.37	0.37	26	67618	67618
86849		4498	86153	1300	0.289	0.00	0.69	27	897	0
86849		4498	86849	3198	0.711	0.00	0.00	27	0	0
89240		46735	86153	4700	0.101	0.00	0.69	27	3243	0

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89240		46735	89240	42035	0.899	0.00	0.00	27		0
90801	D	1503164	90791	751582	0.500	2.80	3.00	28	2254746	2104430
90801	D	1503164	90792	751582	0.500	2.80	3.25	28	2442642	2104430
90802	D	4022	90791	2011	0.500	3.01	3.00	28	6033	6053
90802	D	4022	90792	2011	0.500	3.01	3.25	28	6536	6053
90802	D	4022	90785	4022	1.000	3.01	CP	28		12106
90804	D	761480	90832	761480	1.000	1.21	1.50	28	1142220	921391
90805	D	1504700	90833	1128525	0.750	1.37	1.50	28	1692788	1546079
90805	D	1504700	Savings	376175	0.250	1.37	0.00	28	0	515360
90805	D	1504700	99211	146708	0.097	0.00	0.18	28	26407	0
90805	D	1504700	99212	564263	0.375	0.00	0.48	28	270846	0
90805	D	1504700	99213	394984	0.263	0.00	0.97	28	383134	0
90805	D	1504700	99214	11285	0.007	0.00	1.50	28	16928	0
90805	D	1504700	99215	11285	0.007	0.00	2.11	28	23811	0
90806	D	6270188	90834	6270188	1.000	1.86	2.00	28	12540376	11662550
90806	D	6270188	90863	7500	0.001	0.00	CP	57		0
90807	D	957341	90836	718006	0.750	2.02	1.90	28	1364211	1450372
90807	D	957341	Savings	239335	0.250	2.02	0.00	28	0	483457
90807	D	957341	99211	93341	0.098	0.00	0.18	28	16801	0
90807	D	957341	99212	359003	0.375	0.00	0.48	28	172321	0
90807	D	957341	99213	251302	0.262	0.00	0.97	28	243763	0
90807	D	957341	99214	7180	0.007	0.00	1.50	28	10770	0
90807	D	957341	99215	7180	0.007	0.00	2.11	28	15150	0
90808	D	397592	90837	393616	0.990	2.79	3.00	28	1180848	1098189
90808	D	397592	90839	2982	0.008	0.00	CP	28		0
90808	D	397592	90840	994	0.003	0.00	CP	28		0
90809	D	35445	90838	26584	0.750	2.95	2.50	28	66460	78423
90809	D	35445	Savings	8861	0.250	2.95	0.00	28	0	26140
90809	D	35445	99211	3456	0.098	0.00	0.18	28	622	0
90809	D	35445	99212	13292	0.375	0.00	0.48	28	6380	0
90809	D	35445	99213	9304	0.262	0.00	0.97	28	9025	0
90809	D	35445	99214	266	0.008	0.00	1.50	28	399	0
90809	D	35445	99215	266	0.008	0.00	2.11	28	561	0
90810	D	6659	90832	6659	1.000	1.32	1.50	28	9989	8790
90810	D	6659	90785	6659	1.000	0.00	CP	28		0
90811	D	7477	90833	5608	0.750	1.48	1.50	28	8412	8300
90811	D	7477	90785	5608	0.750	0.00	CP	28		0
90811	D	7477	Savings	1869	0.250	1.48		28	0	2766

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90811	D	7477	99211	729	0.097	0.00	0.18	28	131	0
90811	D	7477	99212	2804	0.375	0.00	0.48	28	1346	0
90811	D	7477	99213	1963	0.263	0.00	0.97	28	1904	0
90811	D	7477	99214	56	0.007	0.00	1.50	28	84	0
90811	D	7477	99215	56	0.007	0.00	2.11	28	118	0
90812	D	16358	90834	16358	1.000	1.97	2.00	28	32716	32225
90812	D	16358	90785	16358	1.000	0.00	CP	28		0
90813	D	2314	90836	1736	0.750	2.13	1.90	28	3298	3698
90813	D	2314	90785	1736	0.750	0.00	CP	28		0
90813	D	2314	Savings	579	0.250	2.13	0.00	28	0	1233
90813	D	2314	99211	226	0.098	0.00	0.18	28	41	0
90813	D	2314	99212	868	0.375	0.00	0.48	28	417	0
90813	D	2314	99213	607	0.262	0.00	0.97	28	589	0
90813	D	2314	99214	17	0.007	0.00	1.50	28	26	0
90813	D	2314	99215	17	0.007	0.00	2.11	28	36	0
90814	D	5571	90837	5515	0.990	2.90	3.00	28	16545	15994
90814	D	5571	90785	5515	0.990	0.00	CP	28		0
90814	D	5571	90839	42	0.008	0.00	CP	28		0
90814	D	5571	90840	14	0.003	0.00	CP	28		0
90815	D	237	90838	178	0.751	2.90	2.50	28	445	516
90815	D	237	90785	178	0.751	0.00	CP	28		0
90815	D	237	Savings	59	0.249	2.90	0.00	28	0	171
90815	D	237	99211	23	0.097	0.00	0.18	28	4	0
90815	D	237	99212	89	0.376	0.00	0.48	28	43	0
90815	D	237	99213	62	0.262	0.00	0.97	28	60	0
90815	D	237	99214	2	0.008	0.00	1.50	28	3	0
90815	D	237	99215	2	0.008	0.00	2.11	28	4	0
90816	D	1444154	90832	1444154	1.000	1.25	1.50	28	2166231	1805193
90817	D	404537	90833	303403	0.750	1.41	1.50	28	455105	427798
90817	D	404537	Savings	101134	0.250	1.41	0.00	28	0	142599
90817	D	404537	99231	151702	0.375	0.00	0.76	28	115294	0
90817	D	404537	99232	136531	0.337	0.00	1.39	28	189778	0
90817	D	404537	99233	15170	0.037	0.00	2.00	28	30340	0
90818	D	1448066	90834	1448066	1.000	1.89	2.00	28	2896132	2736845
90819	D	100561	90836	75421	0.750	2.05	1.90	28	143300	154613
90819	D	100561	Savings	25140	0.250	2.05	0.00	28	0	51537
90819	D	100561	99231	37711	0.375	0.00	0.76	28	28660	0
90819	D	100561	99232	33939	0.337	0.00	1.39	28	47175	0

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90819	D	100561	99233	3771	0.037	0.00	2.00	28	7542	0
90821	D	22844	90837	22616	0.990	2.83	3.00	28	67848	64003
90821	D	22844	90839	171	0.007	0.00	CP	28		0
90821	D	22844	90840	57	0.002	0.00	CP	28		0
90822	D	5799	90838	4349	0.750	2.99	2.50	28	10873	13004
90822	D	5799	Savings	1450	0.250	2.99	0.00	28	0	4336
90822	D	5799	99211	566	0.098	0.00	0.18	28	102	0
90822	D	5799	99212	2175	0.375	0.00	0.48	28	1044	0
90822	D	5799	99213	1522	0.262	0.00	0.97	28	1476	0
90822	D	5799	99214	43	0.007	0.00	1.50	28	65	0
90822	D	5799	99215	43	0.007	0.00	2.11	28	91	0
90823	D	2176	90832	2176	1.000	1.36	1.50	28	3264	2959
90823	D	2176	90785	2176	1.000	0.00	CP	28		0
90824	D	2419	90833	1814	0.750	1.52	1.50	28	2721	2757
90824	D	2419	90785	1814	0.750	0.00	CP	28		0
90824	D	2419	Savings	605	0.250	1.52	0.00	28	0	920
90824	D	2419	99231	907	0.375	0.00	0.76	28	689	0
90824	D	2419	99232	816	0.337	0.00	1.39	28	1134	0
90824	D	2419	99233	91	0.038	0.00	2.00	28	182	0
90826	D	1564	90834	1564	1.000	2.01	2.00	28	3128	3144
90826	D	1564	90785	1564	1.000	0.00	CP	28		0
90827	D	220	90836	165	0.750	2.16	1.90	28	314	356
90827	D	220	90785	165	0.750	0.00	CP	28		0
90827	D	220	Savings	55	0.250	2.16	0.00	28	0	119
90827	D	220	99231	83	0.377	0.00	0.76	28	63	0
90827	D	220	99232	74	0.336	0.00	1.39	28	103	0
90827	D	220	99233	8	0.036	0.00	2.00	28	16	0
90828	D	20	90837	19	0.950	2.94	3.00	28	57	56
90828	D	20	90785	19	0.950	0.00	CP	28		0
90828	D	20	90839	1	0.050	0.00	CP	28		0
90828	D	20	90840	1	0.050	0.00	CP	28		0
90829	D	14	90838	11	0.786	3.10	2.50	28	28	34
90829	D	14	90785	11	0.786	0.00	CP	28		0
90829	D	14	Savings	3	0.214	3.10	0.00	28	0	9
90829	D	14	99231	5	0.357	0.00	0.76	28	4	0
90829	D	14	99232	5	0.357	0.00	1.39	28	7	0
90829	D	14	99233	1	0.071	0.00	2.00	28	2	0
90845		5365	90845	5365	1.000	1.79	2.10	28	11267	9603

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90846		26202	90846	26202	1.000	1.83	2.40	28	62885	47950	
90847		222713	90847	222713	1.000	2.21	2.50	28	556783	492196	
90853		1265355	90853	1265355	1.000	0.59	0.59	28	746559	746559	
90857	D	32524	90853	32524	1.000	0.63	0.59	28	19189	20490	
90857	D	32524	90785	32524	1.000	0.00	CP	28		0	
90862	D	5348548	99211	695311	0.130	0.95	0.18	28	125156	660545	
90862	D	5348548	99212	2139419	0.400	0.95	0.48	28	1026921	2032448	
90862	D	5348548	99213	1925477	0.360	0.95	0.97	28	1867713	1829203	
90862	D	5348548	99214	53485	0.010	0.95	1.50	28	80228	50811	
90862	D	5348548	99215	53485	0.010	0.95	2.11	28	112853	50811	
90862	D	5348548	99231	320913	0.060	0.95	0.76	28	243894	304867	
90862	D	5348548	99232	160456	0.030	0.95	1.39	28	223034	152434	
0242T	D		91112	900			2.10	29	1890	0	
92286		113864	92286	113864	1.000	0.66	0.40	30	45546	75150	
92287		2958	92287	2958	1.000	0.81	0.81	30	2396	2396	
92982	D	26848	92920	26848	1.000	10.96	9.00	31	241632	294254	
92984	D	7153	92921	7368	1.030	2.97	4.00	31	29470	21882	
92995	D	1167	92924	1167	1.000	12.07	11.00	31	12837	14086	
92996	D	231	92925	231	1.000	3.26	5.00	31	1155	753	
92980	D	322682	92928	225877	0.700	14.82	10.49	31	2369454	4782147	*
92980	D	322682	92933	9680	0.030	14.82	12.32	31	119263		
92980	D	322682	92937	16134	0.050	14.82	10.49	31	169247		
92980	D	322682	92941	80671	0.250	14.82	12.32	31	993861		
92980	D	322682	92943	19361	0.060	14.82	12.32	31	238527		
92981	D	38315	92929	36399	0.950	4.16	4.44	31	161613	159390	*
92981	D	38315	92934	383	0.010	4.16	5.50	31	2107		
92981	D	38315	92938	1916	0.050	4.16	6.00	31	11495		
92981	D	38315	92944	766	0.020	4.16	6.00	31	4598		
93620		54655	93620	20448	0.374	11.57	11.57	32	236583	236583	
93620		54655	Savings	34207	0.626	5.79	0.00	32	0	197887	*
93651	D	37585	93653	15598	0.415	16.23	15.00	32	233970	253156	
93651	D	37585	93656	15598	0.415	16.23	20.02	32	312272	253156	
93651	D	37585	93655	3194	0.085	16.23	9.00	32	28746	51839	
93651	D	37585	93657	3195	0.085	16.23	10.00	32	31950	51855	
93652	D	3384	93654	3012	0.890	17.65	20.00	32	60240	53162	
93652	D	3384	93655	186	0.055	17.65	9.00	32	1674	3283	
93652	D	3384	93657	186	0.055	17.65	10.00	32	1860	3283	

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93613		28109	93613	3092	0.110	6.99	6.99	32	21613	21613	
93613		28109	Savings	25017	0.890	6.99	0.00	32	0	174869	
93621		37218	93621	6699	0.180	2.10	2.10	32	14068	14068	
93621		37218	Savings	30519	0.820	2.10	0.00	32	0	64090	
93462		5052	93656	4547	0.900	3.73	20.02	32	91031	16960	*
93462		5052	93462	505	0.100	3.73	3.73	32	1884	1884	
95010	D	80259	95017	60194	0.750	0.11	0.07	33	4214	6621	
95010	D	80259	95018	20065	0.250	0.11	0.14	33	2809	2207	
95015	D	56202	Savings	56202	1.000	0.06	0.00	33	0	3372	
95075	D	2311	95076	2078	0.899	0.95	2.11	34	4385	1974	
95075	D	2311	95079	233	0.101	0.95	1.68	34	391	221	
99354		251643	Savings	233	0.001	1.77	0.00	34	0	412	
99354		251643	99354	251410	0.999	1.77	1.77	34	444996	444996	
99355		27098	Savings	233	0.009	1.77	0.00	34	0	412	
99355		27098	99355	26865	0.991	1.77	1.77	34	47551	47551	
95810		311700	95782	0	1.000	2.50	3.00	35	0	0	
95811		330732	95783	0	1.000	2.60	3.20	35	0	0	
95860		262621	95860	5264	0.020	0.96	0.96	36	5053	5053	
95860		262621	95886	257357	0.980	0.96	0.92	36	236768	247063	
95861		374908	95886	367628	0.981	1.54	0.92	36	338218	566147	
95861		374908	95861	7280	0.019	1.54	1.54	36	11211	11211	
95863		15405	95886	15262	0.991	1.87	0.92	36	14041	28540	
95863		15405	95863	143	0.009	1.87	1.87	36	267	267	
95864		19335	95886	19153	0.991	1.99	0.92	36	17621	38114	
95864		19335	95864	182	0.009	1.99	1.99	36	362	362	
95865		1191	95865	1191	1.000	1.57	1.57	36	1870	1870	
95866		233	95866	233	1.000	1.25	1.25	36	291	291	
95867		3828	95867	39	0.010	0.79	0.79	36	31	31	
95867		3828	95887	3789	0.990	0.79	0.73	36	2766	2993	
95868		2586	95868	26	0.010	1.18	1.18	36	31	31	
95868		2586	95887	2560	0.990	1.18	0.73	36	1869	3021	
95869		6392	95869	61	0.010	0.37	0.37	36	23	23	
95869		6392	95887	6331	0.990	0.37	0.73	36	4622	2342	
95870		6392	95870	6392	1.000	0.37	0.37	36	2365	2365	
95900	D	1352877	Savings	1,081,688	0.800	0.42	0.00	36	0	454309	
95900	D	1352877	95907	27,058	0.020	0.42	1.00	36	27058	11364	
95900	D	1352877	95908	112,096	0.083	0.42	1.68	36	188320	47080	

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
95900	D	1352877	95909	68,874	0.051	0.42	2.28	36	157032	28927
95900	D	1352877	95910	39,684	0.029	0.42	2.90	36	115085	16667
95900	D	1352877	95911	14,241	0.011	0.42	3.44	36	48988	5981
95900	D	1352877	95912	8,235	0.006	0.42	4.10	36	33763	3459
95900	D	1352877	95913	1,002	0.001	0.42	4.30	36	4309	421
95903	D	2108664	Savings	1,685,975	0.800	0.60	0.00	36	0	1011585
95903	D	2108664	95907	42,173	0.020	0.60	1.00	36	42173	25304
95903	D	2108664	95908	174,718	0.083	0.60	1.68	36	293526	104831
95903	D	2108664	95909	107,350	0.051	0.60	2.28	36	244758	64410
95903	D	2108664	95910	61,854	0.029	0.60	2.90	36	179377	37112
95903	D	2108664	95911	22,196	0.011	0.60	3.44	36	76356	13318
95903	D	2108664	95912	12,835	0.006	0.60	4.10	36	52625	7701
95903	D	2108664	95913	1,562	0.001	0.60	4.30	36	6716	937
95904	D	3651015	Savings	2,919,156	0.800	0.34	0.00	36	0	992513
95904	D	3651015	95907	73,020	0.020	0.34	1.00	36	73020	24827
95904	D	3651015	95908	302,513	0.083	0.34	1.68	36	508221	102854
95904	D	3651015	95909	185,870	0.051	0.34	2.28	36	423783	63196
95904	D	3651015	95910	107,096	0.029	0.34	2.90	36	310580	36413
95904	D	3651015	95911	38,432	0.011	0.34	3.44	36	132205	13067
95904	D	3651015	95912	22,224	0.006	0.34	4.10	36	91117	7556
95904	D	3651015	95913	2,704	0.001	0.34	4.30	36	11629	920
95934	D	381339	Savings	304,898	0.800	0.51	0.00	36	0	155498
95934	D	381339	95907	7,627	0.020	0.51	1.00	36	7627	3890
95934	D	381339	95908	31,597	0.083	0.51	1.68	36	53082	16114
95934	D	381339	95909	19,414	0.051	0.51	2.28	36	44263	9901
95934	D	381339	95910	11,186	0.029	0.51	2.90	36	32439	5705
95934	D	381339	95911	4,014	0.011	0.51	3.44	36	13808	2047
95934	D	381339	95912	2,321	0.006	0.51	4.10	36	9517	1184
95934	D	381339	95913	282	0.001	0.51	4.30	36	1215	144
95936	D	23549	Savings	18,829	0.800	0.55	0.00	36	0	10356
95936	D	23549	95907	471	0.020	0.55	1.00	36	471	259
95936	D	23549	95908	1,951	0.083	0.55	1.68	36	3278	1073
95936	D	23549	95909	1,199	0.051	0.55	2.28	36	2733	659
95936	D	23549	95910	691	0.029	0.55	2.90	36	2003	380
95936	D	23549	95911	248	0.011	0.55	3.44	36	853	136
95936	D	23549	95912	143	0.006	0.55	4.10	36	588	79
95936	D	23549	95913	17	0.001	0.55	4.30	36	75	10
95921		77970	95921	17,153	0.220	0.90	0.90	37	15438	15438

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs	
95922		67156	95922	1,343	0.020	0.96	0.96	37	1289	1289	
95922		67156	Savings	65,813	0.980	0.96	0.00	37	0	63180	
95921		77970	95924	18,244	0.234	0.90	1.86	37	33934	16420	
95922		67156	95924	46,337	0.690	0.96	1.86	37	86187	44484	
95923		5526	95923	5,526	1.000	0.90	0.90	37	4973	4973	
95921		77970	95943	42,572	0.546	0.90	0.90	37	38315	38315	*
95920	D	150666	95940	3767	0.025	2.11	0.60	38	2260	7948	
95920	D	150666	95941	146899	0.975	2.11	2.00	38	293798	309957	
99288		0	99485	0	1.000	0.00	1.50	39	0	0	*
99288		0	99486	0	1.000	0.00	1.30	39	0	0	*
99288		0	99288	0	1.000	0.00	0.00	39	0	0	
11300		88442	11300	88442	1.000	0.51	0.60	40	53065	45105	
11301		176259	11301	176259	1.000	0.85	0.90	40	158633	149820	
11302		107174	11302	107174	1.000	1.05	1.16	40	124322	112533	
11303		16945	11303	16945	1.000	1.24	1.25	40	21181	21012	
11305		115473	11305	115473	1.000	0.67	0.80	40	92378	77367	
11306		104350	11306	104350	1.000	0.99	1.18	40	123133	103307	
11307		49955	11307	49955	1.000	1.14	1.20	40	59946	56949	
11308		11389	11308	11389	1.000	1.41	1.46	40	16628	16058	
11310		85938	11310	85938	1.000	0.73	1.19	40	102266	62735	
11311		119760	11311	119760	1.000	1.05	1.43	40	171257	125748	
11312		52616	11312	52616	1.000	1.20	1.80	40	94709	63139	
11313		7226	11313	7226	1.000	1.62	2.00	40	14452	11706	
13100		5175	13100	5175	1.000	3.17	3.00	41	15525	16405	
13101		59565	13101	59565	1.000	3.96	3.50	41	208478	235877	
13102		16473	13102	16473	1.000	1.24	1.24	41	20427	20427	
13120		7851	13120	7851	1.000	3.35	3.23	41	25359	26301	
13121		97197	13121	97197	1.000	4.42	4.00	41	388788	429611	
13122		16519	13122	16519	1.000	1.44	1.44	41	23787	23787	
13131		32877	13131	32877	1.000	3.83	3.73	41	122631	125919	
13132		188152	13132	188152	1.000	6.00	4.78	41	899367	1128912	
13133		11022	13133	11022	1.000	2.19	2.19	41	24138	24138	
13150		2391	13150	2391	1.000	3.85	3.85	41	9205	9205	
13151		30307	13151	30307	1.000	4.49	4.34	41	131532	136078	
13152		43417	13152	43417	1.000	6.37	5.34	41	231847	276566	
13153		1171	13153	1171	1.000	2.38	2.38	41	2787	2787	
arthrocentesis								42			

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
33405		31094	33405	31094	1.000	41.32	41.32	43	1284804	1284804
33430		8309	33430	8309	1.000	50.93	50.93	43	423177	423177
33533		74561	33533	74561	1.000	33.75	34.98	43	2608144	2516434
35475		34402	35475	34402	1.000	9.48	6.60	44	227053	326131
35476		262150	35476	262150	1.000	6.03	5.10	44	1336965	1580765
47600		17084	47600	17084	1.000	17.48	20.00	45	341680	298628
47605		4201	47605	4201	1.000	15.98	21.00	45	88221	67132
50590		54419	50590	54419	1.000	9.77	9.77	46	531674	531674
53850		15222	53850	15222	1.000	10.08	10.08	47	153438	153438
CT angio								48		
CT abdomen								49		
76830		457192	76830	457192	1.000	0.69	0.69	50	315462	315462
76872		261922	76872	261922	1.000	0.69	0.69	50	180726	180726
77301		90639	77301	90639	1.000	7.99	7.99	51	724206	724206
92083		2608269	92083	2600000	0.997	0.50	0.50	52	1300000	1300000
93015		1711584	93015	1711584	1.000	0.75	0.75	53	1283688	1283688
93016		1122304	93016	1122304	1.000	0.45	0.45	53	505037	505037
93018		1293317	93018	1293317	1.000	0.30	0.30	53	387995	387995
93925		586176	93925	586176	1.000	0.58	0.90	54	527558	339982
93926		209208	93926	209208	1.000	0.39	0.70	54	146446	81591
93970		1599899	93970	1599899	1.000	0.68	0.70	54	1119929	1087931
									180117301	180837173

Total Source RVUs	180,837,173
Total New/Revised RVUs	180,117,301
RVU Difference	719,872
CF	34.0376
CF Redistribution	$24,502,710

Notes:

Tab 3:

CPT code 24160 was referred to the CPT Editorial Panel and will be re-reviewed in CPT 2014.

Tab 9:

Category III codes are based off 2011 Medicare estimated utilization

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs

Tab 14:

Utilization crosswalk for deleted code 37203 reflects utilization transitioning to code 37193 (RUC recommendation in April 2011)

Tab 25

Represents left over utilization from 83912 from CPT 2012 Molecular Pathology recommendations

Tab 28

90845 reflects the 2011 RUC recommendation

Tab 30

92287 - Referring to CPT Assistant

Tab 31

New coding structure results in percentages greater than 100. Please see specialty rationale located in the tab for further explanatio

Tab 32

93620 represents a work RVU of 5.79 reduced by the MPPR rule.

Utilization for 93462 represents specialty estimate from April 2010 RUC Meeting

Tab 35

While the pediatric polysomnography codes are currently billed under the adult codes (non-Medicare population), the pediatric codes will not be performed in the Medicare population and thus will not affect the utilization levels for the current adult codes.

Tab 36

Utilization for 95860 reflects modified utilization from bundled code 95886 reviewed in Tab 31 from April 2011
Utilization for 95861 reflects modified utilization from bundled code 95886 reviewed in Tab 31 from April 2011
Utilization for 95863 reflects modified utilization from bundled code 95886 reviewed in Tab 31 from April 2011
Utilization for 95867 reflects modified utilization from bundled code 95887 reviewed in Tab 31 from April 2011
Utilization for 95868 reflects modified utilization from bundled code 95887 reviewed in Tab 31 from April 2011
Utilization for 95869 reflects modified utilization from bundled code 95887 reviewed in Tab 31 from April 2011

Tab 37

CPT code 95943 will be reviewed by the RUC in October 2012. The update crosswalk will be provided in the October Submission

April 2012 RUC Submission
Utilization Crosswalk

CPT Source	Deleted	Source 2010 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2010)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs

Tab 39

Represents pediatric codes not reported in the Medicare population

New Technology/New Services List

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0300XT	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	September 2013		☐
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		☐
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013		☐
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013		☐
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013		☐
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012		☐
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012		☐
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	☑
20986		Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
20987		Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21016	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21557	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21558	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
21935	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21936	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012		☐
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012		☐
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012		☐
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
22904	Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
22905	Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23078	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24079	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
25077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25078	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26117	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26118	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27049	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27059	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27329	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27364	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27615	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27616	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28046	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28047	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2012	Review family volume	☐
29582	Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	September 2015		☐
29583	Application of multi-layer compression system; upper arm and forearm	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	September 2015		☐
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	September 2015		☐
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	☑
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014		☐
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014		☐
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	September 2014		☐
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	September 2014		☐
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	September 2014		☐
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013		☐
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	September 2013		☐
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014		☐
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		☐
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		☐
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		☐
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013		☐
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		☐
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014		☐
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014		☐
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014		☐
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	September 2015		☐
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	September 2015		☐
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	September 2016		☐
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014		☐
43273	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatoscopy	13	CPT 2009	September 2012		☐
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012		☐
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013		☐
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013		☐
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	September 2016		☐
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013		☐
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014		☐
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014		☐
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		☐
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		☐
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		☐
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		☐
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013		☐
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014		☐
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2012		☐
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013		☐
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013		☐
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	☐
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	☐
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	☐
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	☐
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identifiy codes and claims data for all hysterectomy procedures when re-reviewed.	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identifiy codes and claims data for all hysterectomy procedures when re-reviewed.	☐
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identifiy codes and claims data for all hysterectomy procedures when re-reviewed.	☐
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identifiy codes and claims data for all hysterectomy procedures when re-reviewed.	☐
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012		☐
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012		☐
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	September 2014		☐
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014		☐
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012		☐
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012		☐
65778	Placement of amniotic membrane on the ocular surface for wound healing; self-retaining	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014		☐
65779	Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014		☐
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014		☐
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	September 2014		☐
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	September 2014		☐
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013		☐
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013		☐
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	☑
75558		Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75560		Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	☑
75562		Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75564		Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		☐
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		☐
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		☐
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		☐
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	Apr 2010	Ultrasound of Extremity	17	CPT 2011	September 2014		☐
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Apr 2010	Ultrasound of Extremity	17	CPT 2011	September 2014		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	September 2015		☐
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	September 2016		☐
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove “tumor imaging.” Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove “tumor imaging.” Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	☐
78813	Positron emission tomography (PET) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove “tumor imaging.” Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	☐
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove “tumor imaging.” Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove “tumor imaging.” Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	☐
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove “tumor imaging.” Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	☐
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	September 2016		☐
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	September 2016		☐
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	September 2016		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81217	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	September 2015		☐
81241	F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	September 2015		☐
81243	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81244	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81252	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81253	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81275	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015		☐
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016		☐
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), IVS14+1G>A variant F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-1a/b (L33P) Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-2a/b (T145M) Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-3a/b (I843S) Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-4a/b (R143Q) Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-5a/b (K505E) Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-6a/b (R489Q) Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-9a/b (V837M)Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-15a/b(S682Y) SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant							

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABL (c-abl oncogene 1, receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E) APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed CCND1/IGH (BCL1/IgH, t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative, and quantitative, if performed CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2]) CYP3A4 (cytochrome P450, family 3, subfamily A, polypeptide 4) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) CYP3A5 (cytochrome P450, family 3, subfamily A, polypeptide 5) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy, type 1), evaluation to detect abnormal (eg, expanded) alleles F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I]) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia), common variants (eg, 1138G>A, 1138G>C) FIP1L1/PDGFRA (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, Q188R,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	S135L, K285N, T138M, L195P, Y209C, IVS2-2A>G, P171S, del5kb, N314D, L218L/N314D) HBB (hemoglobin, beta) (eg, sickle cell anemia, hemoglobin C, hemoglobin E), common variants (eg, HbS, HbC, HbE) HTT (huntingtin) (eg, Huntington disease), evaluation to detect abnormal (eg, expanded) alleles RUNX1/RUNX1T1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed SEPT9 (Septin 9) (eg, colon cancer), methylation analysis TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), common variants (eg, *2, *3) VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M, R816W, R854Q)							

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon) CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer) KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), common variants (eg, D816V, D816Y, D816F) MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), common variants (eg, W515A, W515K, W515L, W515R) TCD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ABL1 (c-abl oncogene 1, receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), variants in the kinase domain DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) GJB1 (gap junction protein, beta 1) (eg, Charcot-Marie-Tooth X-linked), full gene sequence JAK2 (Janus kinase 2) (eg, myeloproliferative disorder), exon 12 sequence and exon 13 sequence, if performed KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma), gene analysis, variant(s) in exon 2 MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), exon 10 sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) BTD (biotinidase) (eg, biotinidase deficiency), full gene sequence CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy type 1), characterization of abnormal (eg, expanded) alleles EGR2 (early growth response 2) (eg, Charcot-Marie-Tooth), full gene sequence FKRP (Fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence FOXG1 (forkhead box G1) (eg, Rett syndrome), full gene sequence FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4A and 4B haplotypes) HBB (hemoglobin, beta, Beta-Globin) (eg, thalassemia), full gene sequence KIT (C-kit) (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, GIST, acute myeloid leukemia, melanoma), targeted gene analysis (eg, exons 8, 11, 13, 17, 18) LITAF (lipopolysaccharide-induced TNF factor) (eg, Charcot-Marie-Tooth), full gene sequence MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence NRAS (neuroblastoma RAS viral oncogene homolog) (eg, colorectal carcinoma), exon 1 and exon 2 sequences PDGFRA (platelet-derived growth factor receptor alpha polypeptide) (eg, gastrointestinal stromal tumor), targeted sequence analysis (eg, exons 12, 18) RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma),	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	common variants (eg, M918T, 2647_2648delinsTT, A883F) SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37)							
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence FKTN (fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence MPZ (myelin protein zero) (eg, Charcot-Marie-Tooth), full gene sequence NEFL (neurofilament, light polypeptide) (eg, Charcot-Marie-Tooth), full gene sequence RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence TGFBR2 (transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence THRB (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome, tumor samples), full gene sequence or targeted sequence analysis of >5 exons VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) CAPN3 (Calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, calpainopathy), full gene sequence Cytogenomic microarray analysis, neoplasia (eg, interrogation of copy number, and loss-of-heterozygosity via single nucleotide polymorphism [SNP]-based comparative genomic hybridization [CGH] microarray analysis) GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence PAH (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence POLG (polymerase [DNA directed], gamma) (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease types 1 and 3), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015		☐
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	September 2016		☐
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	September 2016		☐
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdisection	12	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdisection	12	CPT 2008	September 2013	Review in 2 years (Sept 2013) to gather more data and determine if there are more efficiencies.	☐
88384	Array-based evaluation of multiple molecular probes; 11 through 50 probes	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
88385	Array-based evaluation of multiple molecular probes; 51 through 250 probes	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88386	Array-based evaluation of multiple molecular probes; 251 through 500 probes	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013		☐
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013		☐
90769		Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90770		Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90771		Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	September 2015		☐
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	September 2015		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	September 2015		☐
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	September 2016		☐
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014		☐
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	September 2014		☐
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014		☐
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014		☐
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014		☐
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93288	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93289	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93290	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93292	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, review(s) and report(s)	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim physician analysis, review(s) and report(s)	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012		☐
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014		☐
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014		☐
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014		☐
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013		☐
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013		☐
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013		☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	September 2014		☐
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	September 2014		☐
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012		☐
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	September 2014		☐
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013		☐
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	September 2016	The RUC recommends that these services be reviewed in 3 years to review the number of times this service is reported together by the same physician on the same day once this utilization data is available.	☐

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	September 2016	The RUC recommends that these services be reviewed in 3 years to review the number of times this service is reported together by the same physician on the same day once this utilization data is available.	☐
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

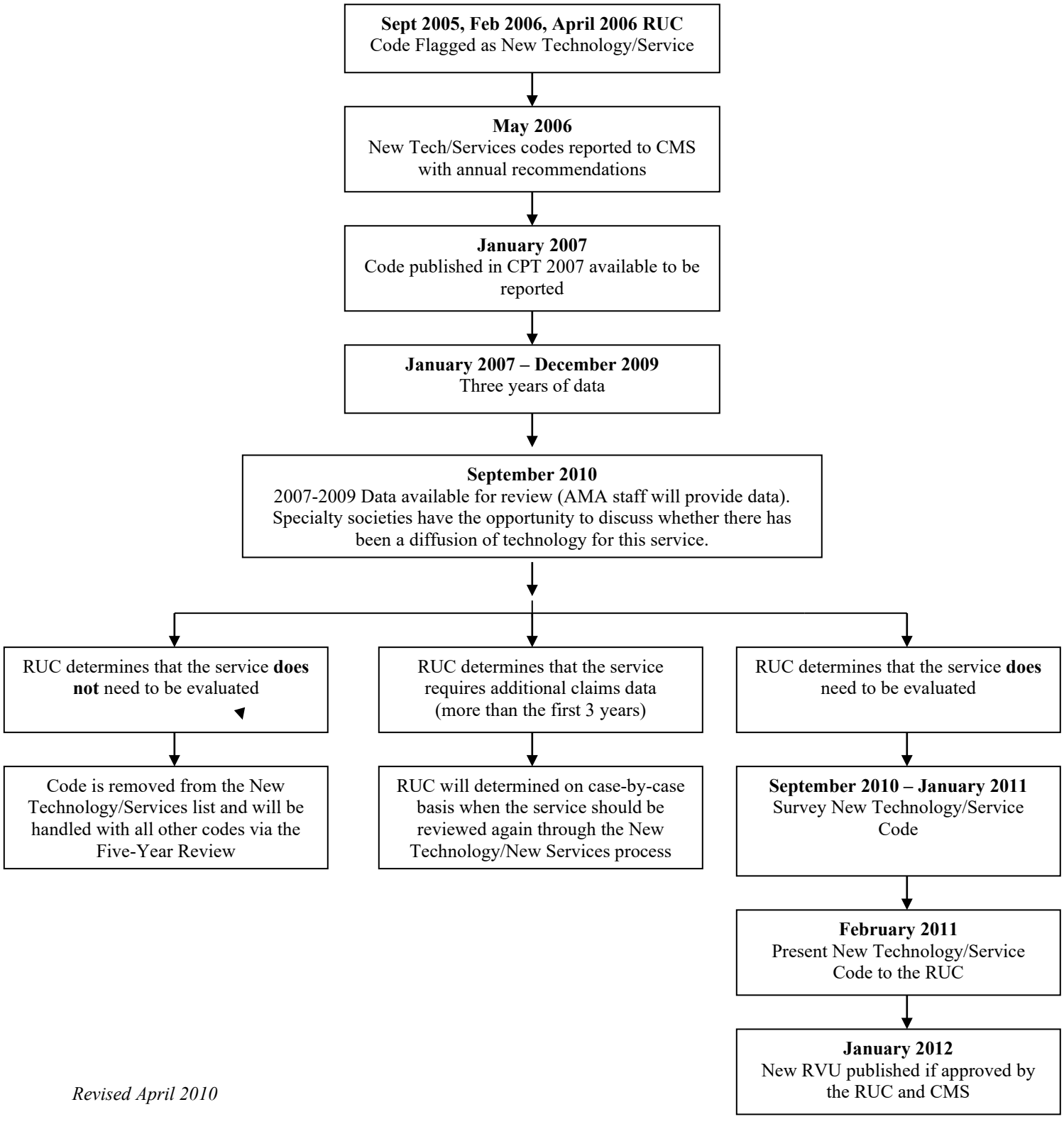
CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑

CPT Code	2012 Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99364	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



Revised April 2010

Multi-Specialty Points of Comparison (CPT Order)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
10060		010	1.22	APMA, ACS	Total:	526,284		**Sept05**
Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single					NF Total	249,183	Top NF PODIATRY	
					Fac Total	20,060	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
16	15	10	57									1			

IWPUT 0.0153

Specialty(s) Performing Procedure

49.6% PODIATRY
12.5% FAMILY PRACTICE
11.9% DERMATOLOGY

11042		000	1.01	APMA, ACS	Total:	1,290,599		**Feb10**
Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less					NF Total	327,278	Top NF PODIATRY	
					Fac Total	179,604	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
11	15	10	36												

IWPUT 0.0369

Specialty(s) Performing Procedure

36.8% PODIATRY
17.6% GENERAL SURGERY
8.8% FAMILY PRACTICE

11043		000	2.70	APMA, ACS	Total:	192,920		**April10**
Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less					NF Total	27,806	Top NF PODIATRY	
					Fac Total	37,879	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
41	30	15	86												

IWPUT 0.0506

Specialty(s) Performing Procedure

26.7% GENERAL SURGERY
22.6% PODIATRY
9.4% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11044		000	4.10	APMA, ACS	Total:	53,754		April10
Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less					NF Total	4,931	Top NF PODIATRY	
					Fac Total	12,270	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
51	45	20	116												

IWPUT 0.0605

Specialty(s) Performing Procedure

31.5% GENERAL SURGERY
22.4% PODIATRY
11.7% ORTHOPEDIC SURGERY

11100		000	0.81	AAD	Total:	2,702,008		Aug05
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion					NF Total	2,222,866	Top NF DERMATOLOGY	
					Fac Total	59,140	Top Fac DERMATOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	12	5	22												

IWPUT 0.0488

Specialty(s) Performing Procedure

84.5% DERMATOLOGY
5.4% PHYSICIANS ASSISTANT
2.5% FAMILY PRACTICE

11400		010	0.90	AAD	Total:	43,795		Aug05
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less					NF Total	14,757	Top NF DERMATOLOGY	
					Fac Total	1,713	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	5	36									1			

IWPUT 0.0196

Specialty(s) Performing Procedure

34.4% DERMATOLOGY
27.1% FAMILY PRACTICE
11.6% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11402		010	1.45	AAD	Total:	117,444		Aug05
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm					NF Total	54,334	Top NF DERMATOLOGY	
					Fac Total	9,015	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	5	56									1			

IWPUT 0.0254

Specialty(s) Performing Procedure

47.5% DERMATOLOGY
20.5% GENERAL SURGERY
13.2% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11403		010	1.84	AAD, ACS	Total:	52,154		Aug05
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm					NF Total	18,585	Top NF DERMATOLOGY	
					Fac Total	7,598	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
20	30	10	76									1			

IWPUT 0.0253

Specialty(s) Performing Procedure

36.7% DERMATOLOGY
31.0% GENERAL SURGERY
13.3% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11440		010	1.05	AAD	Total:	49,087		Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less					NF Total	12,434	Top NF OPHTHALMOLOGY	
					Fac Total	2,008	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	5	36									1			

IWPUT 0.0346

Specialty(s) Performing Procedure

29.4% OPHTHALMOLOGY
25.9% DERMATOLOGY
12.4% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11441		010	1.53	AAO-HNS, AAD	Total:	55,270		Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm					NF Total	19,255	Top NF DERMATOLOGY	
					Fac Total	2,888	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	5	51									1			

IWPUT 0.0357

Specialty(s) Performing Procedure

35.5% DERMATOLOGY
16.3% PLASTIC AND RECONSTUCTIVE SURGERY
11.0% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11442		010	1.77	AAD	Total:	47,795		Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm					NF Total	17,018	Top NF DERMATOLOGY	
					Fac Total	3,592	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	5	56									1			

IWPUT 0.0382

Specialty(s) Performing Procedure

36.5% DERMATOLOGY
20.1% PLASTIC AND RECONSTUCTIVE SURGERY
13.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11443		010	2.34	AAO-HNS, ASPS, AAD	Total:	13,828		Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm					NF Total	4,196	Top NF DERMATOLOGY	
					Fac Total	1,422	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
20	30	10	76									1			

IWPUT 0.0420

Specialty(s) Performing Procedure

31.1% DERMATOLOGY
21.5% PLASTIC AND RECONSTUCTIVE SURGERY
15.4% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11601		010	2.07	AAD	Total:	37,103		Aug05
Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm					NF Total	21,909	Top NF DERMATOLOGY	
					Fac Total	1,026	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	5	63										1		

IWPUT 0.0326

Specialty(s) Performing Procedure

60.4% DERMATOLOGY
12.9% FAMILY PRACTICE
8.7% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11604		010	3.17	ACS, AAD	Total:	30,427		Aug05
Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm					NF Total	15,694	Top NF DERMATOLOGY	
					Fac Total	3,038	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	40	10	103										1		

IWPUT 0.0344

Specialty(s) Performing Procedure

54.2% DERMATOLOGY
17.5% GENERAL SURGERY
12.9% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11623		010	3.11	AAO-HNS, ASPS, AAD	Total:	26,337		Aug05
Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm					NF Total	14,535	Top NF DERMATOLOGY	
					Fac Total	2,088	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	30	10	93										1		

IWPUT 0.0439

Specialty(s) Performing Procedure

56.9% DERMATOLOGY
14.8% PLASTIC AND RECONSTUCTIVE SURGERY
10.9% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11641		010	2.17	AAD	Total:	66,697		Aug05
Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm					NF Total	38,542	Top NF DERMATOLOGY	
					Fac Total	3,396	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	5	63										1		

IWPUT 0.0376

Specialty(s) Performing Procedure

58.7% DERMATOLOGY
13.5% PLASTIC AND RECONSTUCTIVE SURGERY
7.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11642		010	2.62	AAD, AAO-HNS	Total:	136,818		Aug05
Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm					NF Total	84,081	Top NF DERMATOLOGY	
					Fac Total	10,001	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	25	5	68										1		

IWPUT 0.0481

Specialty(s) Performing Procedure

62.7% DERMATOLOGY
15.7% PLASTIC AND RECONSTUCTIVE SURGERY
6.7% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11643		010	3.42	AAD, ASPS	Total:	47,757		Aug05
Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm					NF Total	22,169	Top NF DERMATOLOGY	
					Fac Total	5,845	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	30	10	93										1		

IWPUT 0.0542

Specialty(s) Performing Procedure

48.0% DERMATOLOGY
22.1% PLASTIC AND RECONSTUCTIVE SURGERY
11.1% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12001		000	0.84	ACEP, AAFP	Total:	179,272		April10
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less					NF Total	18,260	Top NF FAMILY PRACTICE	
					Fac Total	85,187	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	5	22												

IWPUT 0.0586

Specialty(s) Performing Procedure

50.1% EMERGENCY MEDICINE
15.8% FAMILY PRACTICE
15.2% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12002		000	1.14	ACEP, AAFP	Total:	139,131		April10
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm					NF Total	11,425	Top NF FAMILY PRACTICE	
					Fac Total	74,047	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	15	5	27												

IWPUT 0.0590

Specialty(s) Performing Procedure

55.5% EMERGENCY MEDICINE
13.7% FAMILY PRACTICE
13.7% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12004		000	1.44	ACEP, AAFP	Total:	21,241		April10
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm					NF Total	1,390	Top NF FAMILY PRACTICE	
					Fac Total	11,909	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	17	5	29												

IWPUT 0.0697

Specialty(s) Performing Procedure

57.9% EMERGENCY MEDICINE
12.5% PHYSICIANS ASSISTANT
12.2% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12011		000	1.07	ACEP, AAFP	Total:	88,270		April10
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less					NF Total	4,015	Top NF FAMILY PRACTICE	
					Fac Total	53,647	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	12	5	24												

IWPUT 0.0680

Specialty(s) Performing Procedure

62.1% EMERGENCY MEDICINE
13.2% PHYSICIANS ASSISTANT
9.8% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12013		000	1.22	ACEP, AAFP	Total:	50,284		April10
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm					NF Total	2,010	Top NF FAMILY PRACTICE	
					Fac Total	32,691	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	15	5	27												

IWPUT 0.0644

Specialty(s) Performing Procedure

66.2% EMERGENCY MEDICINE
11.6% PHYSICIANS ASSISTANT
9.6% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12052		010	2.87	ADA, ASPS, AAO-HNS, ACEP	Total:	75,927		Aug05
Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm					NF Total	47,416	Top NF DERMATOLOGY	
					Fac Total	6,179	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
14	30	10	70									1			

IWPUT 0.0641

Specialty(s) Performing Procedure

65.2% DERMATOLOGY
10.2% PLASTIC AND RECONSTUCTIVE SURGERY
8.5% EMERGENCY MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
13121		010	4.42	AAO-HNS, ASPS, AAD	Total:	97,197		**Aug05**
Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm					NF Total	70,188	Top NF DERMATOLOGY	
					Fac Total	5,418	Top Fac DERMATOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	60	15	117										2		

IWPUT 0.0483

Specialty(s) Performing Procedure

77.8% DERMATOLOGY
10.3% PLASTIC AND RECONSTUCTIVE SURGERY
2.6% GENERAL SURGERY

14000		090	6.37	AAD, AAO-HNS, ACS, ASPS	Total:	10,319		**Oct08**	
Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less					NF Total	3,457	Top NF DERMATOLOGY		
					Fac Total	1,834	Top Fac PLASTIC AND RECONSTUCTIVE SURG		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
25	64	22	192										3.5		

IWPUT 0.0300

Specialty(s) Performing Procedure

35.9% DERMATOLOGY
32.9% PLASTIC AND RECONSTUCTIVE SURGERY
20.3% GENERAL SURGERY

14001		090	8.78	AAD, AAO-HNS, ACS, ASPS	Total:	9,240		**Oct08**	
Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm					NF Total	2,962	Top NF DERMATOLOGY		
					Fac Total	1,863	Top Fac GENERAL SURGERY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
49	105	26	291						0.5				4		

IWPUT 0.0266

Specialty(s) Performing Procedure

36.6% DERMATOLOGY
30.6% PLASTIC AND RECONSTUCTIVE SURGERY
21.5% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
14020		090	7.22	AAD, AAO-HNS, ACS, ASPS	Total:	23,697		Oct08
Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less					NF Total	10,165	Top NF DERMATOLOGY	
					Fac Total	4,406	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
29	78	24	223										4		

IWPUT 0.0276

Specialty(s) Performing Procedure

46.9% DERMATOLOGY
34.4% PLASTIC AND RECONSTUCTIVE SURGERY
7.4% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
14060		090	9.23	AAD, AAO-HNS, ACS, ASPS	Total:	96,958		Oct08
Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less					NF Total	46,804	Top NF DERMATOLOGY	
					Fac Total	13,800	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	60	15	183									2	2		

IWPUT 0.0899

Specialty(s) Performing Procedure

55.0% DERMATOLOGY
22.7% PLASTIC AND RECONSTUCTIVE SURGERY
11.3% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15002		000	3.65	ABA, ACS, ASPS	Total:	17,179		April06
Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children					NF Total	455	Top NF PODIATRY	
					Fac Total	7,458	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
75	20	20	115												

IWPUT 0.0868

Specialty(s) Performing Procedure

46.0% PLASTIC AND RECONSTUCTIVE SURGERY
25.5% GENERAL SURGERY
8.9% PODIATRY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15003		ZZZ	0.80	ABA, ACS, ASPS	Total:	34,973		**April06**
Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)					NF Total	47	Top NF	PLASTIC AND RECONSTUCTIVE SURG
					Fac Total	19,742	Top Fac	GENERAL SURGERY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15	1	16												

IWPUT 0.0518

Specialty(s) Performing Procedure

56.5% GENERAL SURGERY
36.7% PLASTIC AND RECONSTUCTIVE SURGERY
3.7% CRITICAL CARE (INTENSIVISTS)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15004		000	4.58	ABA, ACS, ASPS	Total:	21,344		**April06**
Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children					NF Total	3,438	Top NF	PODIATRY
					Fac Total	5,143	Top Fac	PLASTIC AND RECONSTUCTIVE SURG

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
75	45	30	150												

IWPUT 0.0543

Specialty(s) Performing Procedure

32.3% PODIATRY
30.2% PLASTIC AND RECONSTUCTIVE SURGERY
8.8% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15576		090	9.37	AAO_HNS, ACS, ASPS	Total:	3,935		**Oct08**
Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral					NF Total	930	Top NF	DERMATOLOGY
					Fac Total	1,164	Top Fac	PLASTIC AND RECONSTUCTIVE SURG

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
70	90	30	271						0.5			1	2		

IWPUT 0.0484

Specialty(s) Performing Procedure

33.7% PLASTIC AND RECONSTUCTIVE SURGERY
30.1% DERMATOLOGY
18.6% OPHTHALMOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15738		090	19.04	ASPS	Total:	5,393		**Aug95**
Muscle, myocutaneous, or fasciocutaneous flap; lower extremity					NF Total	124	Top NF	PLASTIC AND RECONSTUCTIVE SURG
					Fac Total	3,561	Top Fac	PLASTIC AND RECONSTUCTIVE SURG

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	150	30	460	6					1		1	2	1		

IWPUT 0.0605

Specialty(s) Performing Procedure

68.3% PLASTIC AND RECONSTUCTIVE SURGERY
8.9% GENERAL SURGERY
8.3% VASCULAR SURGERY

15823		090	6.81	AOA	Total:	103,401		**April10**
Blepharoplasty, upper eyelid; with excessive skin weighting down lid					NF Total	11,911	Top NF	OPHTHALMOLOGY
					Fac Total	79,381	Top Fac	OPHTHALMOLOGY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
16	45	10	161						0.5			3	1		

IWPUT 0.0722

Specialty(s) Performing Procedure

88.3% OPHTHALMOLOGY
9.6% PLASTIC AND RECONSTUCTIVE SURGERY
1.7% OTOLARYNGOLOGY

17000		010	0.65	AAD, AAFP	Total:	4,800,111		**Aug05**
Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion					NF Total	3,841,634	Top NF	DERMATOLOGY
					Fac Total	85,836	Top Fac	DERMATOLOGY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	3	2	25									1			

IWPUT 0.0119

Specialty(s) Performing Procedure

81.8% DERMATOLOGY
5.8% FAMILY PRACTICE
4.6% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
20552		000	0.66	AAN, AAOS, APMA, AAPMR, ACRh, AOFAS	Total:	294,594		April02
Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)					NF Total	47,889	Top NF PHYSICAL MEDICINE AND REHABILITA	
					Fac Total	15,862	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	5	3.5	14												

IWPUT 0.0939

Specialty(s) Performing Procedure

17.4% PHYSICAL MEDICINE AND REHABILITATION
14.1% ORTHOPEDIC SURGERY
12.7% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
20553		000	0.75	AAN, AAOS, APMA, AAPMR, ACRh, AOFAS	Total:	165,881		April02
Injection(s); single or multiple trigger point(s), 3 or more muscle(s)					NF Total	39,337	Top NF PHYSICAL MEDICINE AND REHABILITA	
					Fac Total	8,581	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	5	22												

IWPUT 0.0481

Specialty(s) Performing Procedure

25.5% PHYSICAL MEDICINE AND REHABILITATION
15.4% ANESTHESIOLOGY
11.8% INTERVENTIONAL PAIN MANAGEMENT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
21015		090	9.89	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	Total:	2,322		Feb09
Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm					NF Total	262	Top NF DERMATOLOGY	
					Fac Total	853	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
68	75	30	277						0.5			1	3		

IWPUT 0.0527

Specialty(s) Performing Procedure

46.1% PLASTIC AND RECONSTUCTIVE SURGERY
16.8% GENERAL SURGERY
12.2% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
21025		090	10.03	AAOMS, ADA	Total:	1,407		Feb08
Excision of bone (eg, for osteomyelitis or bone abscess); mandible					NF Total	406	Top NF ORAL SURGERY	
					Fac Total	228	Top Fac OTOLARYNGOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
85	90	30	283									2	2		

IWPUT 0.0530

Specialty(s) Performing Procedure

41.3% ORAL SURGERY
37.7% MAXILLOFACIAL SURGERY
16.8% OTOLARYNGOLOGY

21556		090	7.66	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	3,554		Feb09	
Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm					NF Total	131	Top NF GENERAL SURGERY		
					Fac Total	1,377	Top Fac GENERAL SURGERY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
68	60	25	234						0.5			1	2		

IWPUT 0.0455

Specialty(s) Performing Procedure

42.4% GENERAL SURGERY
37.2% OTOLARYNGOLOGY
10.0% PLASTIC AND RECONSTUCTIVE SURGERY

22520		010	9.22	SIR, NASS, ASNR, AAOS, AANS/CNS, ACR	Total:	11,422		Oct10	
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic					NF Total	713	Top NF DIAGNOSTIC RADIOLOGY		
					Fac Total	6,520	Top Fac DIAGNOSTIC RADIOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	30	177						0.5				1		

IWPUT 0.1291

Specialty(s) Performing Procedure

63.3% DIAGNOSTIC RADIOLOGY
10.2% INTERVENTIONAL RADIOLOGY
9.4% ORTHOPEDIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
22521		010	8.65	AANS American College of Radiology American Society of Neuroradiology North American Spine Association Society of Cardiovascular & Interventional Radiology	Total:	12,100		Oct10
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar					NF Total Fac Total	745 6,629	Top NF DIAGNOSTIC RADIOLOGY Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	75	30	177						0.5				1		

IWPUT 0.0759

Specialty(s) Performing Procedure

60.9% DIAGNOSTIC RADIOLOGY
10.4% INTERVENTIONAL RADIOLOGY
9.6% ORTHOPEDIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
22523		010	9.04	AAOS, AANS, ASA, NASS, SIR, ACR, AAPM	Total:	21,675		Oct10
Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic					NF Total Fac Total	37 7,895	Top NF INTERVENTIONAL PAIN MANAGEMENT Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	58	20	180						0.5				1		

IWPUT 0.1009

Specialty(s) Performing Procedure

36.5% ORTHOPEDIC SURGERY
26.9% DIAGNOSTIC RADIOLOGY
23.2% NEUROSURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
22524		010	8.54	AAOS, AANS, ASA, NASS, SIR, ACR, AAPM	Total:	24,197		Oct10
Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar					NF Total	50	Top NF	INTERVENTIONAL PAIN MANAGEMENT
					Fac Total	8,656	Top Fac	ORTHOPEDIC SURGERY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	55	20	177						0.5				1		

IWPUT 0.0973

Specialty(s) Performing Procedure

35.8% ORTHOPEDIC SURGERY
27.2% DIAGNOSTIC RADIOLOGY
23.0% NEUROSURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
24076		090	7.41	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	1,124		Feb09
Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm					NF Total	52	Top NF	GENERAL SURGERY
					Fac Total	412	Top Fac	ORTHOPEDIC SURGERY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
68	60	20	229						0.5			1	2		

IWPUT 0.0432

Specialty(s) Performing Procedure

37.6% GENERAL SURGERY
36.9% ORTHOPEDIC SURGERY
10.2% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
25071		090	5.91	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	Total:	1,154		Feb09
Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater					NF Total	97	Top NF	GENERAL SURGERY
					Fac Total	543	Top Fac	GENERAL SURGERY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	15	178						0.5			1	1		

IWPUT 0.0523

Specialty(s) Performing Procedure

55.5% GENERAL SURGERY
15.8% ORTHOPEDIC SURGERY
13.4% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
25076		090	6.74	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	1,108		Feb09
Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm					NF Total	44	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	485	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	20	206						0.5			1	2		

IWPUT 0.0467

Specialty(s) Performing Procedure

44.8% ORTHOPEDIC SURGERY
18.9% HAND SURGERY
18.1% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
25116		090	7.56	AAOS, ASSH	Total:	1,040		Oct10
Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum					NF Total	8	Top NF ORTHOPEDIC SURGERY	
					Fac Total	545	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
65	60	20	249						0.5			1	3		

IWPUT 0.0307

Specialty(s) Performing Procedure

53.2% ORTHOPEDIC SURGERY
32.8% HAND SURGERY
11.8% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
26113		090	7.13	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	1,028		Feb09
Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater					NF Total	20	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	454	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	58	15	214						0.5			1	2		

IWPUT 0.0449

Specialty(s) Performing Procedure

45.4% ORTHOPEDIC SURGERY
30.2% HAND SURGERY
17.6% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
26116		090	6.74	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	4,403		**Feb09**
Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm					NF Total	78	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	2,338	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	15	201						0.5			1	2		

IWPUT 0.0492

Specialty(s) Performing Procedure

54.3% ORTHOPEDIC SURGERY
31.4% HAND SURGERY
10.9% PLASTIC AND RECONSTUCTIVE SURGERY

26615		090	7.07	ASSH, AAOS	Total:	1,640		**Feb07**
Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone					NF Total	18	Top NF ORTHOPEDIC SURGERY	
					Fac Total	992	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
55	45	20	217						0.5			2	2		

IWPUT 0.0443

Specialty(s) Performing Procedure

61.6% ORTHOPEDIC SURGERY
20.5% HAND SURGERY
15.4% PLASTIC AND RECONSTUCTIVE SURGERY

26735		090	7.42	ASSH, AAOS	Total:	1,522		**Feb07**
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each					NF Total	20	Top NF ORTHOPEDIC SURGERY	
					Fac Total	873	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	60	20	237						0.5			2	2		

IWPUT 0.0372

Specialty(s) Performing Procedure

58.7% ORTHOPEDIC SURGERY
21.6% PLASTIC AND RECONSTUCTIVE SURGERY
18.2% HAND SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
26765		090	5.86	ASSH, AAOS	Total:	1,514		Feb07
Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each					NF Total	68	Top NF ORTHOPEDIC SURGERY	
					Fac Total	709	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
55	45	20	217						0.5			2	2		

IWPUT 0.0174

Specialty(s) Performing Procedure

51.3% ORTHOPEDIC SURGERY
25.0% PLASTIC AND RECONSTUCTIVE SURGERY
17.0% HAND SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
28003		090	9.06	AAOS, APMA	Total:	3,657		Oct10
Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas					NF Total	599	Top NF PODIATRY	
					Fac Total	2,005	Top Fac PODIATRY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
51	53	20	323	1	1				1			2	3		

IWPUT 0.0072

Specialty(s) Performing Procedure

71.2% PODIATRY
11.6% GENERAL SURGERY
11.5% ORTHOPEDIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
29540		000	0.39	APMA	Total:	301,288		April10
Strapping; ankle and/or foot					NF Total	262,389	Top NF PODIATRY	
					Fac Total	2,197	Top Fac PODIATRY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	9	2	18												

IWPUT 0.0209

Specialty(s) Performing Procedure

87.8% PODIATRY
4.3% PHYSICAL THERAPIST (IND.)
2.5% PHYSICAL MEDICINE AND REHABILITATION

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
30901		000	1.10	AAO-HNS	Total:	115,779		**April10**
Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method					NF Total	47,219	Top NF OTOLARYNGOLOGY	
					Fac Total	42,986	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
11	10	5	26												

IWPUT 0.0813

Specialty(s) Performing Procedure

44.4% OTOLARYNGOLOGY
37.7% EMERGENCY MEDICINE
6.2% FAMILY PRACTICE

31500		000	2.33	ASA, ACEP	Total:	274,961		**April07**
Intubation, endotracheal, emergency procedure					NF Total	82	Top NF PULMONARY DISEASE	
					Fac Total	122,834	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	5	10	19												

IWPUT 0.4061

Specialty(s) Performing Procedure

44.7% EMERGENCY MEDICINE
18.1% ANESTHESIOLOGY
12.4% PULMONARY DISEASE

31622		000	2.78	ACCP/ATS	Total:	84,807		**April09**
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)					NF Total	773	Top NF OTOLARYNGOLOGY	
					Fac Total	43,610	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
20	30	15	65												

IWPUT 0.0689

Specialty(s) Performing Procedure

51.6% PULMONARY DISEASE
15.1% THORACIC SURGERY
7.8% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
31628		000	3.80	ACCP/ATS, ACEP	Total:	39,116		April03
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe					NF Total	180	Top NF PULMONARY DISEASE	
					Fac Total	31,383	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	40	20	90												

IWPUT 0.0706

Specialty(s) Performing Procedure

80.7% PULMONARY DISEASE
10.4% INTERNAL MEDICINE
5.8% CRITICAL CARE (INTENSIVISTS)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33207		090	8.05	ACC	Total:	24,763		April07
Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular					NF Total	38	Top NF CARDIOLOGY	
					Fac Total	19,913	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	30	238		1				1				1		

IWPUT 0.0493

Specialty(s) Performing Procedure

80.6% CARDIOLOGY
5.5% GENERAL SURGERY
4.4% THORACIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33213		090	5.53	ACC, HRS	Total:	47,249		Sept11
Insertion of pacemaker pulse generator only; with existing dual leads					NF Total	145	Top NF CARDIOLOGY	
					Fac Total	38,630	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
22	46	20	130						0.5				1		

IWPUT 0.0666

Specialty(s) Performing Procedure

82.1% CARDIOLOGY
4.6% GENERAL SURGERY
4.1% CARDIAC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33240		090	6.05	ACC, HRS	Total:	39,134		**Sept11**
Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead					NF Total	55	Top NF CARDIOLOGY	
					Fac Total	35,106	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
33	45	20	140						0.5				1		

IWPUT 0.0771

Specialty(s) Performing Procedure

89.8% CARDIOLOGY
3.8% INTERNAL MEDICINE
3.1% CARDIAC SURGERY

33249		090	15.17	ACC	Total:	59,749		**May99**
Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber					NF Total	102	Top NF CARDIOLOGY	
					Fac Total	54,140	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	120		249										3		

IWPUT 0.0910

Specialty(s) Performing Procedure

90.8% CARDIOLOGY
4.2% INTERNAL MEDICINE
2.5% CARDIAC SURGERY

33426		090	43.28	STS	Total:	6,246		**Aug05**
Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring					NF Total	5	Top NF CARDIAC SURGERY	
					Fac Total	3,194	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	205	40	776	1	2	3	1		1				1	1	

IWPUT 0.1110

Specialty(s) Performing Procedure

51.2% CARDIAC SURGERY
40.7% THORACIC SURGERY
3.4% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33512		090	43.98	STS	Total:	2,970		Aug05
Coronary artery bypass, vein only; 3 coronary venous grafts					NF Total	5	Top NF CARDIAC SURGERY	
					Fac Total	1,608	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	213	40	832	1	2	4	1		1			1		1	

IWPUT 0.1030

Specialty(s) Performing Procedure

54.3% CARDIAC SURGERY
37.3% THORACIC SURGERY
3.7% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33533		090	33.75	STS	Total:	74,561		Aug05
Coronary artery bypass, using arterial graft(s); single arterial graft					NF Total	64	Top NF CARDIAC SURGERY	
					Fac Total	39,150	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	151	40	675	1	1	3	1		1			1		1	

IWPUT 0.1000

Specialty(s) Performing Procedure

52.6% CARDIAC SURGERY
38.7% THORACIC SURGERY
4.2% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33863		090	58.79	STS	Total:	1,605		Feb10
Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)					NF Total	0	Top NF CARDIAC SURGERY	
					Fac Total	858	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	287	40	905	1	2	3	2		1					1	

IWPUT 0.1210

Specialty(s) Performing Procedure

53.5% CARDIAC SURGERY
37.6% THORACIC SURGERY
4.3% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
36514		000	1.74	ASH	Total:	22,830		**Sept02**
Therapeutic apheresis; for plasma pheresis					NF Total	228	Top NF MEDICAL ONCOLOGY	
					Fac Total	9,793	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
40	20	15	75												

IWPUT 0.0254

Specialty(s) Performing Procedure

43.2% PATHOLOGY
35.0% NEPHROLOGY
3.7% HEMATOLOGY/ONCOLOGY

36556		000	2.50	ACR, ASA, SIR	Total:	516,697		**April03**
Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older					NF Total	447	Top NF NEPHROLOGY	
					Fac Total	160,255	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
25	15	10	50												

IWPUT 0.1192

Specialty(s) Performing Procedure

31.0% ANESTHESIOLOGY
12.9% EMERGENCY MEDICINE
12.2% GENERAL SURGERY

36620		000	1.15	ASA	Total:	565,857		**April07**
Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous					NF Total	191	Top NF PULMONARY DISEASE	
					Fac Total	461,285	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	5	22												

IWPUT 0.0924

Specialty(s) Performing Procedure

81.5% ANESTHESIOLOGY
6.8% CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)
2.7% PULMONARY DISEASE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
37215		090	19.68	AAN, AANS, ACC, ACR ASITN, SCAI, SIR, SVS	Total:	8,795		April04
Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection					NF Total	10	Top NF CARDIOLOGY	
					Fac Total	4,506	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
90	103	30	347		1				1				2		

IWPUT 0.1223

Specialty(s) Performing Procedure

51.3% CARDIOLOGY
19.3% VASCULAR SURGERY
8.2% DIAGNOSTIC RADIOLOGY

38571		010	14.76	AUA	Total:	7,078		Aug95
Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy					NF Total	12	Top NF UROLOGY	
					Fac Total	6,004	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	180		272									2			

IWPUT 0.0692

Specialty(s) Performing Procedure

85.0% UROLOGY
10.4% GYNECOLOGY/ONCOLOGY
3.7% OBSTETRICS/GYNECOLOGY

43760		000	0.90	AGA, ASGE	Total:	59,752		April07
Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance					NF Total	2,585	Top NF GENERAL SURGERY	
					Fac Total	20,108	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
17	10	5	32												

IWPUT 0.0436

Specialty(s) Performing Procedure

33.7% EMERGENCY MEDICINE
33.3% GASTROENTEROLOGY
14.1% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
45300		000	0.80	ASCRS, ACS	Total:	41,863		**Feb07**
Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)					NF Total	24,611	Top NF COLORECTAL SURGERY(FORMERLY P	
					Fac Total	4,150	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	10	27												

IWPUT 0.0419

Specialty(s) Performing Procedure

65.1% COLORECTAL SURGERY(FORMERLY PROCTOLOGY)
24.2% GENERAL SURGERY
3.8% GASTROENTEROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
46600		000	0.55	ASCRS, ACS	Total:	96,854		**Feb07**
Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)					NF Total	41,108	Top NF COLORECTAL SURGERY(FORMERLY P	
					Fac Total	2,690	Top Fac COLORECTAL SURGERY(FORMERLY P	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	5	10	22												

IWPUT 0.0338

Specialty(s) Performing Procedure

45.2% COLORECTAL SURGERY(FORMERLY PROCTOLOGY)
22.6% GENERAL SURGERY
10.6% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
46930		090	1.61	ACS, ASCRoS	Total:	23,167		**April08**
Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)					NF Total	5,026	Top NF GASTROENTEROLOGY	
					Fac Total	2,424	Top Fac GASTROENTEROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
13	5	5	46										1		

IWPUT 0.0474

Specialty(s) Performing Procedure

32.2% GASTROENTEROLOGY
21.1% COLORECTAL SURGERY(FORMERLY PROCTOLOGY)
15.0% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
49440		010	4.18	ACR, SIR	Total:	16,533		**April07**
Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report					NF Total	82	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	10,992	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	38	20	126	1											

IWPUT 0.0529

Specialty(s) Performing Procedure

67.0% DIAGNOSTIC RADIOLOGY
17.1% INTERVENTIONAL RADIOLOGY
9.5% GENERAL SURGERY

50220		090	18.68	AUA	Total:	1,674		**Aug95**
Nephrectomy, including partial ureterectomy, any open approach including rib resection;					NF Total	5	Top NF UROLOGY	
					Fac Total	1,252	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	120	45	432	5					1				3		

IWPUT 0.0695

Specialty(s) Performing Procedure

75.1% UROLOGY
21.5% GENERAL SURGERY
1.3% VASCULAR SURGERY

50546		090	21.87	AUA	Total:	1,972		**May99**
Laparoscopy, surgical; nephrectomy, including partial ureterectomy					NF Total	6	Top NF UROLOGY	
					Fac Total	1,796	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	205	18	466	3					1				2	1	

IWPUT 0.0641

Specialty(s) Performing Procedure

91.4% UROLOGY
8.0% GENERAL SURGERY
0.1% PEDIATRIC MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
50593		010	9.13	SIR, ACR, AUA	Total:	1,352		**April07**
Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy					NF Total	9	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	872	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
65	90	20	217						0.5				1		

IWPUT 0.0640

Specialty(s) Performing Procedure

65.2% DIAGNOSTIC RADIOLOGY
21.1% UROLOGY
13.5% INTERVENTIONAL RADIOLOGY

51102		000	2.70	AUA	Total:	13,947		**April08**
Aspiration of bladder; with insertion of suprapubic catheter					NF Total	1,593	Top NF UROLOGY	
					Fac Total	8,564	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
25	20	15	60												

IWPUT 0.0938

Specialty(s) Performing Procedure

72.8% UROLOGY
10.5% DIAGNOSTIC RADIOLOGY
9.0% OBSTETRICS/GYNECOLOGY

51702		000	0.50	AUA	Total:	202,781		**April02**
Insertion of temporary indwelling bladder catheter; simple (eg, Foley)					NF Total	145,355	Top NF UROLOGY	
					Fac Total	15,125	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	8		8												

IWPUT 0.0625

Specialty(s) Performing Procedure

77.9% UROLOGY
7.8% EMERGENCY MEDICINE
3.4% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
51741		XXX	0.17	AUA	Total:	631,519		**April10**
Complex uroflowmetry (eg, calibrated electronic equipment)					NF Total	528,130	Top NF UROLOGY	
					Fac Total	23,190	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5	2	7												

IWPUT 0.0250

Specialty(s) Performing Procedure

87.3% UROLOGY
7.6% OBSTETRICS/GYNECOLOGY
1.4% INTERNAL MEDICINE

51797		ZZZ	0.80	AUA	Total:	156,207		**April09**
Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)					NF Total	99,137	Top NF UROLOGY	
					Fac Total	12,328	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0533

Specialty(s) Performing Procedure

71.4% UROLOGY
22.5% OBSTETRICS/GYNECOLOGY
1.8% NURSE PRACTITIONERS

52000		000	2.23	AUA	Total:	908,545		**Aug05**
Cystourethroscopy (separate procedure)					NF Total	707,788	Top NF UROLOGY	
					Fac Total	172,040	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
17	15	10	42												

IWPUT 0.1131

Specialty(s) Performing Procedure

96.8% UROLOGY
2.2% OBSTETRICS/GYNECOLOGY
0.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
55876		000	1.73	AUA, ASTRO, ACR	Total:	19,365		April10
Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple					NF Total	12,123	Top NF UROLOGY	
					Fac Total	2,786	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
29	20	10	59												

IWPUT 0.0428

Specialty(s) Performing Procedure

77.0% UROLOGY
17.1% RADIATION ONCOLOGY
3.9% DIAGNOSTIC RADIOLOGY

57267		ZZZ	4.88	ACOG, AUGS	Total:	24,544		April04
Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)					NF Total	147	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	16,878	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	45		45												

IWPUT 0.1084

Specialty(s) Performing Procedure

69.4% OBSTETRICS/GYNECOLOGY
28.1% UROLOGY
1.7% GYNECOLOGY/ONCOLOGY

57452		000	1.50	ACOG, AUGS	Total:	10,829		April02
Colposcopy of the cervix including upper/adjacent vagina;					NF Total	6,670	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	791	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	15	10	40												

IWPUT 0.0627

Specialty(s) Performing Procedure

68.9% OBSTETRICS/GYNECOLOGY
14.4% GYNECOLOGY/ONCOLOGY
10.1% UROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
58150		090	17.31	ACOG	Total:	13,420		**Sept05**
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);					NF Total	63	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	9,952	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	120	30	394	3	1				1				2		

IWPUT 0.0712

Specialty(s) Performing Procedure

74.6% OBSTETRICS/GYNECOLOGY
19.8% GYNECOLOGY/ONCOLOGY
2.6% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
58660		090	11.59	ACOG	Total:	1,833		**April97**
Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)					NF Total	13	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	1,346	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	90	30	210						0.5				1		

IWPUT 0.0916

Specialty(s) Performing Procedure

74.2% OBSTETRICS/GYNECOLOGY
17.1% GENERAL SURGERY
3.7% GYNECOLOGY/ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
58720		090	12.16	ACOG	Total:	4,584		**Sept05**
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)					NF Total	22	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	2,499	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
52	90	30	309	1	1				1			1	1		

IWPUT 0.0621

Specialty(s) Performing Procedure

55.0% OBSTETRICS/GYNECOLOGY
18.9% GYNECOLOGY/ONCOLOGY
17.7% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
60220		090	11.19	ACS, AAO-HNS	Total:	8,652		**April08**
Total thyroid lobectomy, unilateral; with or without isthmusectomy					NF Total	17	Top NF OTOLARYNGOLOGY	
					Fac Total	4,254	Top Fac OTOLARYNGOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
72	90	40	267						0.5				2		

IWPUT 0.0710

Specialty(s) Performing Procedure

49.4% OTOLARYNGOLOGY
44.9% GENERAL SURGERY
2.2% SURGICAL ONCOLOGY

62264		010	4.42	ASA, AAPMR and ASIPP	Total:	14,524		**April02**
Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day					NF Total	2,172	Top NF ANESTHESIOLOGY	
					Fac Total	4,662	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
40	30	20	109						0.5						

IWPUT 0.0812

Specialty(s) Performing Procedure

47.1% ANESTHESIOLOGY
33.9% INTERVENTIONAL PAIN MANAGEMENT
8.5% PAIN MANAGEMENT

62350		010	6.05	AAPM, AAPM&R, AANS, AANS, CNS, ASA, ISIS, NASS, AAPM&R, ISIS, NASS	Total:	6,433		**Oct10**
Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy					NF Total	52	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	1,864	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	20	170						0.5				1		

IWPUT 0.0498

Specialty(s) Performing Procedure

29.0% NEUROSURGERY
27.4% ANESTHESIOLOGY
26.7% INTERVENTIONAL PAIN MANAGEMENT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
62362		010	5.60	AAPM, AAPM&R, AANS, CNS, ASA, ISIS, NASS	Total:	6,268		**Oct10**
Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming					NF Total	20	Top NF ANESTHESIOLOGY	
					Fac Total	2,311	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	20	170						0.5				1		

IWPUT 0.0423

Specialty(s) Performing Procedure

37.0% NEUROSURGERY
23.3% INTERVENTIONAL PAIN MANAGEMENT
22.2% ANESTHESIOLOGY

63661		010	5.08	ISIS, NASS, AANS/CNS, ASA, AAPM	Total:	4,207		**April09**
Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed					NF Total	299	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	914	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	55	20	165						0.5				1		

IWPUT 0.0367

Specialty(s) Performing Procedure

28.5% ANESTHESIOLOGY
27.1% INTERVENTIONAL PAIN MANAGEMENT
14.1% NEUROSURGERY

63685		010	5.19	AAPM, AAPM&R, AANS, AANS, CNS, ASA, ISIS, NASS, AAPM&R, ISIS, NASS	Total:	12,177		**Oct10**
Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling					NF Total	109	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	4,079	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	20	170						0.5				1		

IWPUT 0.0355

Specialty(s) Performing Procedure

33.6% NEUROSURGERY
20.5% INTERVENTIONAL PAIN MANAGEMENT
19.3% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
63688		010	5.30	AAPM, AAPM&R, AANS, AANS, CNS, ASA, ISIS, NASS, AAPM&R, ISIS, NASS	Total:	4,540		**Feb08**
Revision or removal of implanted spinal neurostimulator pulse generator or receiver					NF Total	43	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	1,538	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	55	20	165						0.5				1		

IWPUT 0.0407

Specialty(s) Performing Procedure

34.3% NEUROSURGERY
19.4% INTERVENTIONAL PAIN MANAGEMENT
19.1% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64479		000	2.29	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	43,666		**Oct09**
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level					NF Total	5,564	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	6,283	Top Fac INTERVENTIONAL PAIN MANAGEMENT	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
24	15	10	49												

IWPUT 0.1076

Specialty(s) Performing Procedure

27.1% INTERVENTIONAL PAIN MANAGEMENT
21.8% ANESTHESIOLOGY
17.1% PHYSICAL MEDICINE AND REHABILITATION

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64480		ZZZ	1.20	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	32,822		**Oct09**
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)					NF Total	4,769	Top NF NEUROSURGERY	
					Fac Total	4,243	Top Fac INTERVENTIONAL PAIN MANAGEMENT	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0800

Specialty(s) Performing Procedure

25.5% INTERVENTIONAL PAIN MANAGEMENT
20.4% ANESTHESIOLOGY
16.2% PAIN MANAGEMENT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64483		000	1.90	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	803,663		Oct09
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level					NF Total	116,273	Top NF	INTERVENTIONAL PAIN MANAGEMENT
					Fac Total	119,409	Top Fac	ANESTHESIOLOGY

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
24	15	10	49												

IWPUT 0.0816

Specialty(s) Performing Procedure

28.7% INTERVENTIONAL PAIN MANAGEMENT
25.8% PHYSICAL MEDICINE AND REHABILITATION
24.1% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64484		ZZZ	1.00	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	422,276		Oct09
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)					NF Total	69,293	Top NF	INTERVENTIONAL PAIN MANAGEMENT
					Fac Total	66,023	Top Fac	INTERVENTIONAL PAIN MANAGEMENT

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	10		10												

IWPUT 0.1000

Specialty(s) Performing Procedure

32.0% INTERVENTIONAL PAIN MANAGEMENT
26.6% ANESTHESIOLOGY
17.4% PHYSICAL MEDICINE AND REHABILITATION

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64614		010	2.20	AANS, AAN, AANEM, AAPMR	Total:	59,575		April00
Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)					NF Total	22,927	Top NF	NEUROLOGY
					Fac Total	6,644	Top Fac	PHYSICAL MEDICINE AND REHABILITA

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	15	50												

IWPUT 0.0764

Specialty(s) Performing Procedure

45.7% NEUROLOGY
45.1% PHYSICAL MEDICINE AND REHABILITATION
1.5% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64708		090	6.36	AAOS, ASPS, ASSH, and AOFAS	Total:	3,279		**Oct10**
Neuroplasty, major peripheral nerve, arm or leg, open; other than specified					NF Total	33	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	1,290	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
55	60	15	220						0.5			3	1		

IWPUT 0.0314

Specialty(s) Performing Procedure

39.5% ORTHOPEDIC SURGERY
20.9% PLASTIC AND RECONSTUCTIVE SURGERY
13.7% HAND SURGERY

67820		000	0.71	AAO, AOA(HCPAC)	Total:	332,209		**Aug05**
Correction of trichiasis; epilation, by forceps only					NF Total	226,448	Top NF OPHTHALMOLOGY	
					Fac Total	3,168	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	5	2	15												

IWPUT 0.1001

Specialty(s) Performing Procedure

69.1% OPHTHALMOLOGY
30.5% OPTOMETRY
0.1% PLASTIC AND RECONSTUCTIVE SURGERY

67904		090	7.97	AAO	Total:	45,147		**Aug05**
Repair of blepharoptosis; (tarso) levator resection or advancement, external approach					NF Total	5,307	Top NF OPHTHALMOLOGY	
					Fac Total	36,384	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
35	45	15	185						0.5			3	1		

IWPUT 0.0892

Specialty(s) Performing Procedure

92.3% OPHTHALMOLOGY
6.3% PLASTIC AND RECONSTUCTIVE SURGERY
0.9% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
69210		000	0.61	AAO-HNS	Total:	1,412,292		**Sept05**
Removal impacted cerumen (separate procedure), 1 or both ears					NF Total	592,968	Top NF OTOLARYNGOLOGY	
					Fac Total	29,632	Top Fac OTOLARYNGOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	2	19												

IWPUT 0.0408

Specialty(s) Performing Procedure

44.1% OTOLARYNGOLOGY
22.1% FAMILY PRACTICE
20.0% INTERNAL MEDICINE

70355		XXX	0.20	ADA/AAOMS	Total:	31,988		**Aug05**
Orthopantogram (eg, panoramic x-ray)					NF Total	11,232	Top NF ORAL SURGERY	
					Fac Total	9,609	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5	1	6												

IWPUT 0.0355

Specialty(s) Performing Procedure

40.6% ORAL SURGERY
30.4% DIAGNOSTIC RADIOLOGY
26.9% MAXILLOFACIAL SURGERY

71010		XXX	0.18	ACR	Total:	18,956,128		**Aug05**
Radiologic examination, chest; single view, frontal					NF Total	823,851	Top NF PORTABLE XRAY SUPPLIER	
					Fac Total	16,815,058	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0451

Specialty(s) Performing Procedure

89.9% DIAGNOSTIC RADIOLOGY
5.3% PORTABLE XRAY SUPPLIER
2.2% INTERVENTIONAL RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
71020		XXX	0.22	ACR	Total:	13,329,285		**Aug05**
Radiologic examination, chest, 2 views, frontal and lateral;					NF Total	1,721,776	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	9,205,907	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0584

Specialty(s) Performing Procedure

82.0% DIAGNOSTIC RADIOLOGY
4.3% INTERNAL MEDICINE
4.0% FAMILY PRACTICE

73120		XXX	0.16	AAOS, ACR	Total:	271,925		**Aug05**
Radiologic examination, hand; 2 views					NF Total	62,283	Top NF RHEUMATOLOGY	
					Fac Total	66,243	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0384

Specialty(s) Performing Procedure

35.1% DIAGNOSTIC RADIOLOGY
22.9% RHEUMATOLOGY
17.9% ORTHOPEDIC SURGERY

74020		XXX	0.27	ACR	Total:	797,903		**Aug05**
Radiologic examination, abdomen; complete, including decubitus and/or erect views					NF Total	41,314	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	693,001	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0751

Specialty(s) Performing Procedure

92.0% DIAGNOSTIC RADIOLOGY
2.2% INTERVENTIONAL RADIOLOGY
1.8% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76519		XXX	0.54	AAO	Total:	619,641		Aug05
Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation					NF Total	576,698	Top NF OPHTHALMOLOGY	
					Fac Total	28,584	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
12	5		17												

IWPUT 0.0542

Specialty(s) Performing Procedure

97.7% OPHTHALMOLOGY
1.9% OPTOMETRY
0.2% OTOLARYNGOLOGY

76536		XXX	0.56	ACR, ASNR, TES, AACE	Total:	592,261		April09
Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation					NF Total	144,918	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	257,412	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	10	4	18												

IWPUT 0.0381

Specialty(s) Performing Procedure

67.9% DIAGNOSTIC RADIOLOGY
14.7% ENDOCRINOLOGY
5.4% INTERNAL MEDICINE

76700		XXX	0.81	ACR	Total:	1,040,905		Aug05
Ultrasound, abdominal, real time with image documentation; complete					NF Total	239,697	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	584,744	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	10	4	17												

IWPUT 0.0653

Specialty(s) Performing Procedure

79.2% DIAGNOSTIC RADIOLOGY
5.8% INDEPENDENT DIAGNOSTIC TESTING FACILITY
5.6% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76805		XXX	0.99	ACOG, ACR	Total:	12,521		**April02**
Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation					NF Total	5,353	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	3,783	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	15	6	26												

IWPUT 0.0496

Specialty(s) Performing Procedure

58.4% OBSTETRICS/GYNECOLOGY
37.2% DIAGNOSTIC RADIOLOGY
1.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76815		XXX	0.65	ACOG, ACR	Total:	13,623		**April02**
Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses					NF Total	4,046	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	5,747	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	5.5	5	16												

IWPUT 0.0774

Specialty(s) Performing Procedure

48.5% OBSTETRICS/GYNECOLOGY
44.7% DIAGNOSTIC RADIOLOGY
2.6% EMERGENCY MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76816		XXX	0.85	ACOG, ACR	Total:	14,036		**April02**
Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus					NF Total	7,497	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	4,362	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
6	15	10	31												

IWPUT 0.0328

Specialty(s) Performing Procedure

84.5% OBSTETRICS/GYNECOLOGY
12.8% DIAGNOSTIC RADIOLOGY
0.4% GYNECOLOGY/ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76817		XXX	0.75	ACOG, ACR	Total:	15,358		April02
Ultrasound, pregnant uterus, real time with image documentation, transvaginal					NF Total	5,961	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	6,379	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	8	23												

IWPUT 0.0459

Specialty(s) Performing Procedure

50.9% OBSTETRICS/GYNECOLOGY
45.3% DIAGNOSTIC RADIOLOGY
0.7% INTERVENTIONAL RADIOLOGY

77290		XXX	1.56	ASTRO	Total:	334,547		Aug05
Therapeutic radiology simulation-aided field setting; complex					NF Total	129,327	Top NF RADIATION ONCOLOGY	
					Fac Total	187,175	Top Fac RADIATION ONCOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	70		70												

IWPUT 0.0223

Specialty(s) Performing Procedure

94.6% RADIATION ONCOLOGY
4.1% DIAGNOSTIC RADIOLOGY
0.3% RADIATION THERAPY CENTERS

77421		XXX	0.39	ASTRO	Total:	1,140,462		April05
Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy					NF Total	647,950	Top NF RADIATION ONCOLOGY	
					Fac Total	428,417	Top Fac RADIATION ONCOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	9		9												

IWPUT 0.0433

Specialty(s) Performing Procedure

94.4% RADIATION ONCOLOGY
4.0% DIAGNOSTIC RADIOLOGY
0.7% RADIATION THERAPY CENTERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
78306		XXX	0.86	SNM, ACR	Total:	412,804		Aug05
Bone and/or joint imaging; whole body					NF Total	52,776	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	293,807	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	8	5	18												

IWPUT 0.0795

Specialty(s) Performing Procedure

84.0% DIAGNOSTIC RADIOLOGY
10.8% NUCLEAR MEDICINE
1.6% INTERVENTIONAL RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88112		XXX	1.18	CAP	Total:	937,311		April03
Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal					NF Total	254,533	Top NF PATHOLOGY	
					Fac Total	418,366	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	25	10	43												

IWPUT 0.0311

Specialty(s) Performing Procedure

71.8% PATHOLOGY
23.8% CLINICAL LABORATORY (IND.
4.0% UROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88304		XXX	0.22	CAP, AAD	Total:	1,103,248		April10
					NF Total	175,839	Top NF	CLINICAL LABORATORY (IND.
					Fac Total	731,169	Top Fac	PATHOLOGY

Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pathologic fracture, Bursa/synovial cyst, Carpal tunnel tissue, Cartilage, shavings, Cholesteatoma Colon, colostomy stoma, Conjunctiva - biopsy/pterygium, Cornea Diverticulum - esophagus/small intestine, Dupuytren's contracture tissue, Femoral head, other than fracture, Fissure/fistula, Foreskin, other than newborn, Gallbladder, Ganglion cyst, Hematoma, Hemorrhoids, Hydatid of Morgagni, Intervertebral disc, Joint, loose body, Meniscus Mucocele, salivary, Neuroma - Morton's/traumatic, Pilonidal cyst/sinus, Polyps, inflammatory - nasal/sinusoidal, Skin - cyst/tag/debridement, Soft tissue, debridement, Soft tissue, lipoma, Spermatocele, Tendon/tendon sheath, Testicular appendage, Thrombus or embolus, Tonsil and/or adenoids, Varicocele, Vas deferens, other than sterilization, Vein, varicosity

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0147

Specialty(s) Performing Procedure

78.1% PATHOLOGY
16.7% CLINICAL LABORATORY (IND.
4.1% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88305		XXX	0.75	CAP, AAD	Total:	16,231,440		April10
					NF Total	4,540,988	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	5,811,292	Top Fac PATHOLOGY	

Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of surgical margins, Breast, reduction mammoplasty, Bronchus, biopsy, Cell block, any source, Cervix, biopsy, Colon, biopsy, Duodenum, biopsy, Endocervix, curettings/biopsy, Endometrium, curettings/biopsy, Esophagus, biopsy, Extremity, amputation, traumatic, Fallopian tube, biopsy, Fallopian tube, ectopic pregnancy, Femoral head, fracture, Fingers/toes, amputation, non-traumatic, Gingiva/oral mucosa, biopsy, Heart valve, Joint, resection, Kidney, biopsy, Larynx, biopsy, Leiomyoma(s), uterine myomectomy - without uterus, Lip, biopsy/wedge resection, Lung, transbronchial biopsy, Lymph node, biopsy, Muscle, biopsy, Nasal mucosa, biopsy, Nasopharynx/oropharynx, biopsy, Nerve, biopsy, Odontogenic/dental cyst, Omentum, biopsy, Ovary with or without tube, non-neoplastic, Ovary, biopsy/wedge resection, Parathyroid gland, Peritoneum, biopsy, Pituitary tumor, Placenta, other than third trimester, Pleura/pericardium - biopsy/tissue, Polyp, cervical/endometrial, Polyp, colorectal, Polyp, stomach/small intestine, Prostate, needle biopsy, Prostate, TUR, Salivary gland, biopsy, Sinus, paranasal biopsy, Skin, other than cyst/tag/debridement/plastic repair, Small intestine, biopsy, Soft tissue, other than tumor/mass/lipoma/debridement, Spleen, Stomach, biopsy, Synovium, Testis, other than tumor/biopsy/castration, Thyroglossal duct/brachial cleft cyst, Tongue, biopsy, Tonsil, biopsy, Trachea, biopsy, Ureter, biopsy, Urethra, biopsy, Urinary bladder, biopsy, Uterus, with or without tubes and ovaries, for prolapse, Vagina, biopsy, Vulva/labia, biopsy

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	25		25												

IWPUT 0.0300

Specialty(s) Performing Procedure

58.2% PATHOLOGY
28.3% CLINICAL LABORATORY (IND.
12.0% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88321		XXX	1.63	CAP	Total:	188,503		Aug05
					NF Total	47,313	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	92,321	Top Fac PATHOLOGY	

Consultation and report on referred slides prepared elsewhere

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	50		50												

IWPUT 0.0326

Specialty(s) Performing Procedure

66.3% PATHOLOGY
25.1% CLINICAL LABORATORY (IND.
7.7% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88361		XXX	1.18	CAP, ASC	Total:	150,498		Oct04
Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology					NF Total	38,288	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	59,287	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	40		40												

IWPUT 0.0295

Specialty(s) Performing Procedure

53.4% PATHOLOGY
26.6% CLINICAL LABORATORY (IND.
15.6% HEMATOLOGY/ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88367		XXX	1.30	CAP, ASC	Total:	503,924		Oct09
Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology					NF Total	248,924	Top NF PATHOLOGY	
					Fac Total	20,679	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	42		42												

IWPUT 0.0310

Specialty(s) Performing Procedure

53.5% PATHOLOGY
26.5% CLINICAL LABORATORY (IND.
19.8% UROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90935		000	1.48	RPA	Total:	1,367,649		Oct09
Hemodialysis procedure with single physician evaluation					NF Total	7,986	Top NF NEPHROLOGY	
					Fac Total	1,154,216	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	10	45												

IWPUT 0.0413

Specialty(s) Performing Procedure

85.0% NEPHROLOGY
12.2% INTERNAL MEDICINE
0.9% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90937		000	2.11	RPA	Total:	90,344		**Oct09**
Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription					NF Total	1,062	Top NF NEPHROLOGY	
					Fac Total	72,944	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	40	10	60												

IWPUT 0.0415

Specialty(s) Performing Procedure

81.9% NEPHROLOGY
15.8% INTERNAL MEDICINE
0.8% NEUROLOGY

90945		000	1.56	RPA	Total:	127,219		**Oct09**
Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation					NF Total	643	Top NF NEPHROLOGY	
					Fac Total	109,818	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	27	10	47												

IWPUT 0.0412

Specialty(s) Performing Procedure

86.8% NEPHROLOGY
10.2% INTERNAL MEDICINE
1.0% NEUROLOGY

90960		XXX	5.18	RPA	Total:	2,094,884		**Feb08**
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month					NF Total	1,654,585	Top NF NEPHROLOGY	
					Fac Total	147,574	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	128		128												

IWPUT 0.0405

Specialty(s) Performing Procedure

86.0% NEPHROLOGY
11.8% INTERNAL MEDICINE
1.0% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90961		XXX	4.26	RPA	Total:	622,643		**Feb08**
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month					NF Total	470,161	Top NF NEPHROLOGY	
					Fac Total	50,109	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	113		113												

IWPUT 0.0377

Specialty(s) Performing Procedure

83.6% NEPHROLOGY
11.7% INTERNAL MEDICINE
2.3% NURSE PRACTITIONERS

90962	XXX	3.15	RPA	Total:	187,916		**Feb08**
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month				NF Total	136,679	Top NF NEPHROLOGY	
				Fac Total	15,613	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	63		63												

IWPUT 0.0500

Specialty(s) Performing Procedure

81.0% NEPHROLOGY
13.0% INTERNAL MEDICINE
3.3% NURSE PRACTITIONERS

90966	XXX	4.26	RPA	Total:	222,157		**Feb08**
End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older				NF Total	180,045	Top NF NEPHROLOGY	
				Fac Total	13,528	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	75		75												

IWPUT 0.0568

Specialty(s) Performing Procedure

87.1% NEPHROLOGY
11.0% INTERNAL MEDICINE
0.7% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90969		XXX	0.29	ASPN	Total:	11,267		**Feb08**
End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age					NF Total	3,802	Top NF NEPHROLOGY	
					Fac Total	4,576	Top Fac PEDIATRIC MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	7.27		7												

IWPUT 0.0399

Specialty(s) Performing Procedure

50.3% PEDIATRIC MEDICINE
46.0% NEPHROLOGY
1.4% INTERNAL MEDICINE

90970		XXX	0.14	ASPN	Total:	1,313,833		**Feb08**
End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older					NF Total	1,021,373	Top NF NEPHROLOGY	
					Fac Total	94,863	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	2.5		2												

IWPUT 0.0560

Specialty(s) Performing Procedure

85.0% NEPHROLOGY
10.7% INTERNAL MEDICINE
1.8% NURSE PRACTITIONERS

92002		XXX	0.88	AAO, AOA(HCPAC)	Total:	216,904		**Feb07**
Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient					NF Total	113,341	Top NF OPHTHALMOLOGY	
					Fac Total	6,162	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	15	5	25												

IWPUT 0.0437

Specialty(s) Performing Procedure

55.1% OPHTHALMOLOGY
44.4% OPTOMETRY
0.1% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92004		XXX	1.82	AAO, AOA(HCPAC)	Total:	2,123,579		**Feb07**
Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits					NF Total	1,259,540	Top NF OPHTHALMOLOGY	
					Fac Total	35,191	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	25	10	40												

IWPUT 0.0594

Specialty(s) Performing Procedure

61.0% OPHTHALMOLOGY
38.8% OPTOMETRY
0.0% OTOLARYNGOLOGY

92012		XXX	0.92	AAO, AOA(HCPAC)	Total:	6,697,588		**Feb07**
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient					NF Total	5,489,252	Top NF OPHTHALMOLOGY	
					Fac Total	123,147	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	15	5	25												

IWPUT 0.0464

Specialty(s) Performing Procedure

83.8% OPHTHALMOLOGY
15.9% OPTOMETRY
0.1% OTOLARYNGOLOGY

92014		XXX	1.42	AAO, AOA(HCPAC)	Total:	10,940,913		**Feb07**
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits					NF Total	8,000,829	Top NF OPHTHALMOLOGY	
					Fac Total	159,188	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	24	8	37												

IWPUT 0.0470

Specialty(s) Performing Procedure

74.6% OPHTHALMOLOGY
25.2% OPTOMETRY
0.1% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92025		XXX	0.35	AAO, AOA(HCPAC)	Total:	107,320		Feb06
Computerized corneal topography, unilateral or bilateral, with interpretation and report					NF Total	88,890	Top NF OPHTHALMOLOGY	
					Fac Total	3,550	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	12		17												

IWPUT 0.0198

Specialty(s) Performing Procedure

86.1% OPHTHALMOLOGY
13.6% OPTOMETRY
0.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92081		XXX	0.30	AAO	Total:	117,269		April10
Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)					NF Total	61,431	Top NF OPHTHALMOLOGY	
					Fac Total	1,468	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	7		10												

IWPUT 0.0333

Specialty(s) Performing Procedure

53.6% OPHTHALMOLOGY
41.8% OPTOMETRY
1.8% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92082		XXX	0.40	AAO	Total:	176,773		April10
Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)					NF Total	98,086	Top NF OPHTHALMOLOGY	
					Fac Total	3,565	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	8		11												

IWPUT 0.0416

Specialty(s) Performing Procedure

57.5% OPHTHALMOLOGY
40.8% OPTOMETRY
0.8% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92250		XXX	0.44	AAO, AOA (HCPAC)	Total:	2,162,922		Aug05
Fundus photography with interpretation and report					NF Total	1,279,855	Top NF OPHTHALMOLOGY	
					Fac Total	23,580	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	9	5	14												

IWPUT 0.0364

Specialty(s) Performing Procedure

60.3% OPHTHALMOLOGY
39.2% OPTOMETRY
0.1% ENDOCRINOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92285		XXX	0.05	AAO, AOA (HCPAC)	Total:	305,350		Oct09
External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)					NF Total	190,986	Top NF OPHTHALMOLOGY	
					Fac Total	6,496	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5		5												

IWPUT 0.0100

Specialty(s) Performing Procedure

64.7% OPHTHALMOLOGY
33.0% OPTOMETRY
1.6% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92567		XXX	0.20	AAO-HNS, ASHA	Total:	654,991		April07
Tympanometry (impedance testing)					NF Total	321,094	Top NF AUDIOLOGIST (IND.)	
					Fac Total	2,954	Top Fac AUDIOLOGIST (IND.)	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	4	1	6												

IWPUT 0.0388

Specialty(s) Performing Procedure

49.5% AUDIOLOGIST (IND.)
42.2% OTOLARYNGOLOGY
3.4% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92568		XXX	0.29	AAO-HNS, ASHA	Total:	73,776		**April07**
Acoustic reflex testing, threshold					NF Total	34,938	Top NF OTOLARYNGOLOGY	
					Fac Total	3,387	Top Fac AUDIOLOGIST (IND.)	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	8	1	10												

IWPUT 0.0306

Specialty(s) Performing Procedure

47.4% OTOLARYNGOLOGY
39.6% AUDIOLOGIST (IND.)
4.6% INTERNAL MEDICINE

92604		XXX	1.25	AAO-HNS, ASHA	Total:	11,467		**April07**
Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming					NF Total	7,623	Top NF AUDIOLOGIST (IND.)	
					Fac Total	297	Top Fac AUDIOLOGIST (IND.)	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	50	10	65												

IWPUT 0.0183

Specialty(s) Performing Procedure

69.1% AUDIOLOGIST (IND.)
29.6% OTOLARYNGOLOGY
0.7% THORACIC SURGERY

93010		XXX	0.17	ACC	Total:	19,647,347		**Aug05**
Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only					NF Total	341,269	Top NF CARDIOLOGY	
					Fac Total	11,339,484	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	4	1	5												

IWPUT 0.0369

Specialty(s) Performing Procedure

59.5% CARDIOLOGY
19.8% INTERNAL MEDICINE
15.1% EMERGENCY MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93015		XXX	0.75	ACC	Total:	1,711,584		Aug05
Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report					NF Total	1,502,149	Top NF CARDIOLOGY	
					Fac Total	16	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	15	4	21												

IWPUT 0.0410

Specialty(s) Performing Procedure

87.8% CARDIOLOGY
7.6% INTERNAL MEDICINE
1.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93042		XXX	0.15	ACEP, ACC	Total:	878,371		Oct09
Rhythm ECG, 1-3 leads; interpretation and report only					NF Total	4,043	Top NF CARDIOLOGY	
					Fac Total	437,163	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	3	2	7												

IWPUT 0.0201

Specialty(s) Performing Procedure

49.8% EMERGENCY MEDICINE
28.7% CARDIOLOGY
11.1% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93224		XXX	0.52	ACC	Total:	221,981		April10
External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation					NF Total	175,178	Top NF CARDIOLOGY	
					Fac Total	46	Top Fac INDEPENDENT DIAGNOSTIC TESTING	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	15	7	24												

IWPUT 0.0212

Specialty(s) Performing Procedure

78.9% CARDIOLOGY
13.8% INTERNAL MEDICINE
3.7% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93351		XXX	1.75	ACC	Total:	260,934		April08
	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision				NF Total	219,098	Top NF CARDIOLOGY	
					Fac Total	19,857	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	20	10	35												

IWPUT 0.0707

Specialty(s) Performing Procedure

91.6% CARDIOLOGY
6.6% INTERNAL MEDICINE
0.6% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93922		XXX	0.25	ACR, ACC, SVS	Total:	611,045		April10
	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)				NF Total	105,459	Top NF CARDIOLOGY	
					Fac Total	52,790	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	5	2	10												

IWPUT 0.0276

Specialty(s) Performing Procedure

19.2% CARDIOLOGY
19.2% VASCULAR SURGERY
15.2% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93923		XXX	0.45	ACR, ACC, SVS	Total:	633,077		April10
					NF Total	103,658	Top NF CARDIOLOGY	
					Fac Total	70,502	Top Fac DIAGNOSTIC RADIOLOGY	

Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	10	3	16												

IWPUT 0.0316

Specialty(s) Performing Procedure

25.6% VASCULAR SURGERY
18.8% CARDIOLOGY
15.0% DIAGNOSTIC RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
94002		XXX	1.99	AAP, ASA, ACCP/ATS	Total:	17,392		April06
					NF Total	31	Top NF PULMONARY DISEASE	
					Fac Total	8,361	Top Fac ANESTHESIOLOGY	

Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	30	15	60												

IWPUT 0.0439

Specialty(s) Performing Procedure

48.1% ANESTHESIOLOGY
36.7% PULMONARY DISEASE
7.0% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
94003		XXX	1.37	AAP, ASA, ACCP/ATS	Total:	150,170		**April06**
Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day					NF Total	38	Top NF PULMONARY DISEASE	
					Fac Total	107,251	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	10	40												

IWPUT 0.0461

Specialty(s) Performing Procedure

71.4% PULMONARY DISEASE
12.4% INTERNAL MEDICINE
6.8% CRITICAL CARE (INTENSIVISTS)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
94004		XXX	1.00	AAP, ASA, ACCP/ATS	Total:	38,078		**April06**
Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day					NF Total	3,666	Top NF PULMONARY DISEASE	
					Fac Total	20,802	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	15	10	35												

IWPUT 0.0368

Specialty(s) Performing Procedure

64.3% PULMONARY DISEASE
21.2% INTERNAL MEDICINE
6.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95165		XXX	0.06	AAO-HNS, JCAAI, AAOA	Total:	5,448,102		**Feb06**
Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)					NF Total	2,812,231	Top NF ALLERGY/IMMUNOLOGY	
					Fac Total	6,684	Top Fac ALLERGY/IMMUNOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	3		3												

IWPUT 0.0200

Specialty(s) Performing Procedure

51.7% ALLERGY/IMMUNOLOGY
34.1% OTOLARYNGOLOGY
5.1% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95251		XXX	0.85	AACE	Total:	21,040		Feb05
Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report					NF Total	10,590	Top NF ENDOCRINOLOGY	
					Fac Total	492	Top Fac ENDOCRINOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	30		30												

IWPUT 0.0283

Specialty(s) Performing Procedure

52.7% ENDOCRINOLOGY
28.3% INTERNAL MEDICINE
10.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95805		XXX	1.20	AAN, AASM, ACNS, ACCP/ATS	Total:	7,559		April10
Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness					NF Total	1,308	Top NF NEUROLOGY	
					Fac Total	1,649	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	15	50												

IWPUT 0.0264

Specialty(s) Performing Procedure

38.0% PULMONARY DISEASE
26.6% NEUROLOGY
11.7% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95810		XXX	2.50	AAN, AASM, ACNS, ACCP/ATS	Total:	311,700		April10
Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist					NF Total	67,902	Top NF PULMONARY DISEASE	
					Fac Total	87,701	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	36.5	15	66												

IWPUT 0.0501

Specialty(s) Performing Procedure

49.9% PULMONARY DISEASE
19.3% NEUROLOGY
10.6% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95861		XXX	1.54	AANEM, AAN, AAPMR	Total:	374,908		**Aug05**
Needle electromyography; 2 extremities with or without related paraspinal areas					NF Total	191,592	Top NF NEUROLOGY	
					Fac Total	44,453	Top Fac NEUROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	25	10	50												

IWPUT 0.0392

Specialty(s) Performing Procedure

63.0% NEUROLOGY
26.6% PHYSICAL MEDICINE AND REHABILITATION
2.3% INTERNAL MEDICINE

95874		ZZZ	0.37	AAN, AANEM, AAPM&R	Total:	52,023		**April05**
Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)					NF Total	23,537	Top NF NEUROLOGY	
					Fac Total	6,068	Top Fac NEUROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	20		20												

IWPUT 0.0185

Specialty(s) Performing Procedure

56.9% NEUROLOGY
31.3% PHYSICAL MEDICINE AND REHABILITATION
8.3% OTOLARYNGOLOGY

95971		XXX	0.78	AANS, AAPM, ASA	Total:	26,356		**April04**
Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming					NF Total	11,245	Top NF UROLOGY	
					Fac Total	754	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	20	3	26												

IWPUT 0.0323

Specialty(s) Performing Procedure

43.7% UROLOGY
24.4% OBSTETRICS/GYNECOLOGY
7.8% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95972		XXX	1.50	AANS, AAPM, ASA	Total:	57,891		April04
	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour				NF Total	11,095	Top NF UROLOGY	
					Fac Total	5,901	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	60	5	68												

IWPUT 0.0220

Specialty(s) Performing Procedure

29.4% UROLOGY
20.2% INTERVENTIONAL PAIN MANAGEMENT
17.6% ANESTHESIOLOGY

95991		XXX	0.77	AAPM, ASA, AANS, CNS	Total:	88,496		Feb03
	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill				NF Total	20,613	Top NF ANESTHESIOLOGY	
					Fac Total	9,419	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	7	37												

IWPUT 0.0195

Specialty(s) Performing Procedure

33.9% ANESTHESIOLOGY
25.9% INTERVENTIONAL PAIN MANAGEMENT
15.6% PHYSICAL MEDICINE AND REHABILITATION

96153		XXX	0.10	APA, NASW	Total:	32,431		Feb01
	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)				NF Total	8,844	Top NF CLINICAL PSYCHOLOGIST	
					Fac Total	18,020	Top Fac CLINICAL PSYCHOLOGIST	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0184

Specialty(s) Performing Procedure

82.8% CLINICAL PSYCHOLOGIST
11.2% PSYCHIATRY
2.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96367		ZZZ	0.19	ASH, ASCO, IDSA	Total:	2,148,456		**Oct04**
Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)					NF Total	1,455,881	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	10	Top Fac FAMILY PRACTICE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	5		6												

IWPUT 0.0335

Specialty(s) Performing Procedure

67.8% HEMATOLOGY/ONCOLOGY
20.2% MEDICAL ONCOLOGY
3.3% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96374		XXX	0.18	ACRh, ASH, ASCO	Total:	452,150		**Oct04**
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug					NF Total	122,600	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	420	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	5	2	9												

IWPUT 0.0181

Specialty(s) Performing Procedure

27.1% HEMATOLOGY/ONCOLOGY
13.6% CARDIOLOGY
11.0% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96375		ZZZ	0.10	ACRh, ASH, ASCO	Total:	2,003,993		**Oct04**
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)					NF Total	1,270,830	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	81	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3		4												

IWPUT 0.0259

Specialty(s) Performing Procedure

63.4% HEMATOLOGY/ONCOLOGY
21.4% MEDICAL ONCOLOGY
3.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96401		XXX	0.21	ASH, ASCO	Total:	319,343		**Oct04**
Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic					NF Total	102,419	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	3	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	3	2	9												

IWPUT 0.0252

Specialty(s) Performing Procedure

32.1% HEMATOLOGY/ONCOLOGY
26.1% RHEUMATOLOGY
8.0% ALLERGY/IMMUNOLOGY

96402		XXX	0.19	ASH, AUA	Total:	448,068		**Oct04**
Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic					NF Total	320,150	Top NF UROLOGY	
					Fac Total	13	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	3	2	9												

IWPUT 0.0185

Specialty(s) Performing Procedure

71.5% UROLOGY
17.8% HEMATOLOGY/ONCOLOGY
6.0% MEDICAL ONCOLOGY

96411		ZZZ	0.20	ASH, ASCO	Total:	295,505		**Oct04**
Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)					NF Total	202,141	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	2	Top Fac HEMATOLOGY/ONCOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	4		7												

IWPUT 0.0332

Specialty(s) Performing Procedure

68.4% HEMATOLOGY/ONCOLOGY
22.7% MEDICAL ONCOLOGY
3.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96413		XXX	0.28	ACRh, ASH, ASCO, AGA	Total:	2,289,174		**Oct04**
Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug					NF Total	1,281,676	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	2	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	7	2	13												

IWPUT 0.0208

Specialty(s) Performing Procedure

56.0% HEMATOLOGY/ONCOLOGY
17.9% MEDICAL ONCOLOGY
13.5% RHEUMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96521		XXX	0.21	ASCO	Total:	109,480		**Oct04**
Refilling and maintenance of portable pump					NF Total	43,818	Top NF INFECTIOUS DISEASE	
					Fac Total	2	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	4	2	10												

IWPUT 0.0189

Specialty(s) Performing Procedure

40.0% INFECTIOUS DISEASE
37.0% HEMATOLOGY/ONCOLOGY
12.4% MEDICAL ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99202		XXX	0.93	AAD, APMA, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	3,074,347		**Feb06**
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.					NF Total	723,275	Top NF DERMATOLOGY	
					Fac Total	27,010	Top Fac DERMATOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	15	5	22												

IWPUT 0.0516

Specialty(s) Performing Procedure

24.4% DERMATOLOGY
17.2% PODIATRY
8.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99203		XXX	1.42	APMA, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	9,033,718		**Feb06**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

NF Total	1,297,924	Top NF ORTHOPEDIC SURGERY
Fac Total	65,719	Top Fac ORTHOPEDIC SURGERY

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	20	5	29												

IWPUT 0.0609

Specialty(s) Performing Procedure

15.1% ORTHOPEDIC SURGERY
11.2% PODIATRY
9.5% OTOLARYNGOLOGY

99204		XXX	2.43	APMA, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	8,436,133		**Feb06**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

NF Total	712,297	Top NF INTERNAL MEDICINE
Fac Total	80,861	Top Fac INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	30	10	45												

IWPUT 0.0698

Specialty(s) Performing Procedure

9.4% INTERNAL MEDICINE
8.8% CARDIOLOGY
8.6% OPHTHALMOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99205		XXX	3.17	APMS, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	3,240,750		**Feb06**
					NF Total	359,477	Top NF NEUROLOGY	
					Fac Total	56,951	Top Fac RADIATION ONCOLOGY	

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	45	15	67												

IWPUT 0.0595

Specialty(s) Performing Procedure

12.3% INTERNAL MEDICINE
12.3% NEUROLOGY
10.9% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99211		XXX	0.18	ANA, AAN, AOA, AAFP, ACP, ASCO, TES, ACRh, SGIM	Total:	8,360,950		**Feb06**
					NF Total	2,408,091	Top NF CARDIOLOGY	
					Fac Total	42,790	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5	2	7												

IWPUT 0.0270

Specialty(s) Performing Procedure

29.1% CARDIOLOGY
27.6% INTERNAL MEDICINE
18.3% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99212		XXX	0.48	ANA, AAN, AOA, AAFP, ACP, TES, ACRh, ASCO, SGIM	Total:	19,056,063		Feb06
					NF Total	2,463,694	Top NF DERMATOLOGY	
					Fac Total	168,351	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	10	4	16												

IWPUT 0.0346

Specialty(s) Performing Procedure

13.2% DERMATOLOGY
12.9% PODIATRY
10.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99213		XXX	0.97	ANA, ASCO, ACRh, AAN, AOA, AAFP, TES, ACP, SGIM	Total:	100,611,197		Feb06
					NF Total	21,684,587	Top NF INTERNAL MEDICINE	
					Fac Total	1,365,234	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	15	5	23												

IWPUT 0.0527

Specialty(s) Performing Procedure

22.9% INTERNAL MEDICINE
19.7% FAMILY PRACTICE
6.3% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data				Reviewed by RUC?
99214		XXX	1.50	ANA, ASCO,ACRh, AAN, AOA, AAFP, TES, ACP, SGIM	Total:	78,471,611			Feb06

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

NF Total	19,538,174	Top NF	INTERNAL MEDICINE
Fac Total	1,521,069	Top Fac	INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	25	10	40												

IWPUT 0.0466

Specialty(s) Performing Procedure

26.8% INTERNAL MEDICINE
21.1% FAMILY PRACTICE
11.1% CARDIOLOGY

99215		XXX	2.11	ANA, ACRh, AAN, AOA, AAFP, TES, ACP	Total:	9,976,351			Feb06

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

NF Total	2,591,568	Top NF	INTERNAL MEDICINE
Fac Total	205,834	Top Fac	INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	35	15	55												

IWPUT 0.0475

Specialty(s) Performing Procedure

28.0% INTERNAL MEDICINE
14.7% FAMILY PRACTICE
11.0% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99221		XXX	1.92	AAN, AOA, AAFP, ACP, SGIM, SHM	Total:	1,952,569		Feb06

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

NF Total	46	Top NF	CARDIOLOGY
Fac Total	293,786	Top Fac	INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	30	10	50												

IWPUT 0.0491

Specialty(s) Performing Procedure

15.0% INTERNAL MEDICINE
11.4% CARDIOLOGY
7.9% GASTROENTEROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99222		XXX	2.61	AAN, AOA, AAFP, ACP, SGIM, SHM	Total:	7,451,228		Feb06

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

NF Total	113	Top NF	CARDIOLOGY
Fac Total	1,850,960	Top Fac	INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	40	20	75												

IWPUT 0.0457

Specialty(s) Performing Procedure

24.8% INTERNAL MEDICINE
13.4% CARDIOLOGY
8.7% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data				Reviewed by RUC?
99223		XXX	3.86	AAN, AOA, AAFP, ACP, SGIM, SHM	Total:	11,496,708			Feb06

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

NF Total	27	Top NF	INTERNAL MEDICINE
Fac Total	4,256,172	Top Fac	INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	55	20	90												

IWPUT 0.0559

Specialty(s) Performing Procedure

37.0% INTERNAL MEDICINE
12.8% CARDIOLOGY
6.8% FAMILY PRACTICE

99231		XXX	0.76	IDSA, AAN, AOA, AAFP, ACP, TES, SGIM	Total:	13,056,708			Feb06						

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

NF Total	57	Top NF	INTERNAL MEDICINE
Fac Total	2,908,856	Top Fac	INTERNAL MEDICINE

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	5	20												

IWPUT 0.0536

Specialty(s) Performing Procedure

22.3% INTERNAL MEDICINE
9.6% PSYCHIATRY
8.1% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99232		XXX	1.39	IDSA, AAN, AOA, AAFP, ACP, TES, SGIM,	Total:	50,265,347		Feb06

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

NF Total	166	Top NF	INTERNAL MEDICINE	
Fac Total	18,139,210	Top Fac	INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	10	40												

IWPUT 0.0471

Specialty(s) Performing Procedure

36.1% INTERNAL MEDICINE
10.7% CARDIOLOGY
7.5% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99233		XXX	2.00	IDSA, AAN, AOA, AAFP, ACP, TES, SGIM	Total:	21,650,555		Feb06

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

NF Total	36	Top NF	INTERNAL MEDICINE	
Fac Total	8,549,155	Top Fac	INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	30	15	55												

IWPUT 0.0480

Specialty(s) Performing Procedure

39.5% INTERNAL MEDICINE
11.4% PULMONARY DISEASE
9.9% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99238		XXX	1.28	AOA, AAFP, ACP, SGIM	Total:	4,979,896		Feb06
Hospital discharge day management; 30 minutes or less					NF Total	4	Top NF INTERNAL MEDICINE	
					Fac Total	2,541,864	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	20	10	38												

IWPUT 0.0438

Specialty(s) Performing Procedure

51.0% INTERNAL MEDICINE
17.5% FAMILY PRACTICE
7.5% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99239		XXX	1.90	ACP, AAFP, AOA, SGIM	Total:	3,444,392		Feb06
Hospital discharge day management; more than 30 minutes					NF Total	337	Top NF INTERNAL MEDICINE	
					Fac Total	2,307,131	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	30	15	55												

IWPUT 0.0447

Specialty(s) Performing Procedure

67.0% INTERNAL MEDICINE
12.6% FAMILY PRACTICE
3.6% PSYCHIATRY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99281		XXX	0.45	ACEP	Total:	81,426		Sept05
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.					NF Total	3	Top NF GENERAL PRACTICE	
					Fac Total	40,744	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	7	4	13												

IWPUT 0.0451

Specialty(s) Performing Procedure

50.0% EMERGENCY MEDICINE
13.0% FAMILY PRACTICE
10.9% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99282		XXX	0.88	ACEP	Total:	533,649		Sept05
	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.				NF Total	1	Top NF GENERAL PRACTICE	
					Fac Total	309,836	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	10	5	18												

IWPUT 0.0701

Specialty(s) Performing Procedure

58.1% EMERGENCY MEDICINE
12.6% FAMILY PRACTICE
11.5% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99283		XXX	1.34	ACEP	Total:	3,833,077		Sept05
	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.				NF Total	1	Top NF GASTROENTEROLOGY	
					Fac Total	2,529,043	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	18	7	30												

IWPUT 0.0595

Specialty(s) Performing Procedure

66.0% EMERGENCY MEDICINE
12.1% PHYSICIANS ASSISTANT
8.2% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99284		XXX	2.56	ACEP	Total:	5,555,818		Sept05
					NF Total	1	Top NF	MULTISPECIALTY CLINIC OR GROUP P
					Fac Total	4,212,207	Top Fac	EMERGENCY MEDICINE

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	25	10	40												

IWPUT 0.0890

Specialty(s) Performing Procedure

75.8% EMERGENCY MEDICINE
7.1% PHYSICIANS ASSISTANT
6.5% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99285		XXX	3.80	ACEP	Total:	9,188,374		Sept05
					NF Total	3	Top NF	PHYSICIANS ASSISTANT
					Fac Total	7,821,602	Top Fac	EMERGENCY MEDICINE

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	40	15	63												

IWPUT 0.0821

Specialty(s) Performing Procedure

85.1% EMERGENCY MEDICINE
4.3% FAMILY PRACTICE
3.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99291		XXX	4.50	ACCP, ATS, SCCM, ASCO, ASA, ASH	Total:	4,752,537		Aug05
Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes					NF Total	4,068	Top NF FAMILY PRACTICE	
					Fac Total	1,132,760	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	40	15	70												

IWPUT 0.0957

Specialty(s) Performing Procedure

23.8% EMERGENCY MEDICINE
23.2% PULMONARY DISEASE
22.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99292		ZZZ	2.25	ACCP, ATS, SCCM, ASCO, ASA, ASH	Total:	415,547		Aug05
Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)					NF Total	336	Top NF FAMILY PRACTICE	
					Fac Total	99,493	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	30		30												

IWPUT 0.0750

Specialty(s) Performing Procedure

24.0% EMERGENCY MEDICINE
21.1% INTERNAL MEDICINE
18.7% PULMONARY DISEASE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99304		XXX	1.64	AGA	Total:	295,356		Feb07
					NF Total	35,634	Top NF PODIATRY	
					Fac Total	39,684	Top Fac INTERNAL MEDICINE	

Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	23	10	43												

IWPUT 0.0518

Specialty(s) Performing Procedure

20.6% INTERNAL MEDICINE
18.9% PODIATRY
18.3% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99306		XXX	3.06	AGA	Total:	1,271,496		Feb07
					NF Total	175,210	Top NF INTERNAL MEDICINE	
					Fac Total	436,579	Top Fac INTERNAL MEDICINE	

Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	45	20	80												

IWPUT 0.0506

Specialty(s) Performing Procedure

48.1% INTERNAL MEDICINE
22.3% FAMILY PRACTICE
5.9% GERIATRIC MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99308		XXX	1.16	AGA	Total:	9,319,037		Feb07
					NF Total	1,256,751	Top NF INTERNAL MEDICINE	
					Fac Total	2,000,744	Top Fac INTERNAL MEDICINE	

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	15	9	31												

IWPUT 0.0534

Specialty(s) Performing Procedure

35.0% INTERNAL MEDICINE
19.6% FAMILY PRACTICE
19.2% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99309		XXX	1.55	AGA	Total:	6,686,008		Feb07
					NF Total	835,683	Top NF INTERNAL MEDICINE	
					Fac Total	1,376,960	Top Fac INTERNAL MEDICINE	

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	10	45												

IWPUT 0.0441

Specialty(s) Performing Procedure

33.1% INTERNAL MEDICINE
23.7% NURSE PRACTITIONERS
17.9% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99310		XXX	2.35	AGA	Total:	1,122,900		Feb07
					NF Total	119,731	Top NF NURSE PRACTITIONERS	
					Fac Total	217,416	Top Fac INTERNAL MEDICINE	

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	35	20	70												

IWPUT 0.0447

Specialty(s) Performing Procedure

29.5% INTERNAL MEDICINE
26.8% NURSE PRACTITIONERS
15.9% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99318		XXX	1.71	AGA	Total:	139,627		Feb07
					NF Total	25,287	Top NF INTERNAL MEDICINE	
					Fac Total	25,845	Top Fac INTERNAL MEDICINE	

Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	27	10	47												

IWPUT 0.0467

Specialty(s) Performing Procedure

36.6% INTERNAL MEDICINE
27.6% FAMILY PRACTICE
19.8% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99326		XXX	2.63	Home Care Medicine and Collaborators	Total:	37,184		Feb07
					NF Total	9,070	Top NF PODIATRY	
					Fac Total	37	Top Fac INTERNAL MEDICINE	

Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	45	17	77												

IWPUT 0.0425

Specialty(s) Performing Procedure

24.4% PODIATRY
22.1% INTERNAL MEDICINE
15.8% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99327		XXX	3.46	Home Care Medicine and Collaborators	Total:	35,739		Feb07
					NF Total	10,378	Top NF INTERNAL MEDICINE	
					Fac Total	35	Top Fac INTERNAL MEDICINE	

Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	60	25	100												

IWPUT 0.0427

Specialty(s) Performing Procedure

29.1% INTERNAL MEDICINE
21.2% NURSE PRACTITIONERS
19.9% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99335		XXX	1.72	Home Care Medicine and Collaborators	Total:	712,101		Feb07
					NF Total	204,166	Top NF INTERNAL MEDICINE	
					Fac Total	679	Top Fac INTERNAL MEDICINE	

Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
9	25	10	44												

IWPUT 0.0518

Specialty(s) Performing Procedure

28.8% INTERNAL MEDICINE
17.6% FAMILY PRACTICE
17.3% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99336		XXX	2.46	Home Care Medicine and Collaborators	Total:	714,841		Feb07
					NF Total	204,886	Top NF INTERNAL MEDICINE	
					Fac Total	610	Top Fac GENERAL SURGERY	

Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	40	15	65												

IWPUT 0.0475

Specialty(s) Performing Procedure

28.7% INTERNAL MEDICINE
25.3% NURSE PRACTITIONERS
20.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99337		XXX	3.58	Home Care Medicine and Collaborators	Total:	182,268		Feb07
					NF Total	53,083	Top NF NURSE PRACTITIONERS	
					Fac Total	63	Top Fac INTERNAL MEDICINE	

Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	60	20	95												

IWPUT 0.0466

Specialty(s) Performing Procedure

29.1% NURSE PRACTITIONERS
25.4% INTERNAL MEDICINE
19.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99343		XXX	2.53	AAFP, APMA, AAP	Total:	47,590		Feb07
					NF Total	27,426	Top NF PODIATRY	
					Fac Total		Top Fac	

Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	45	17	77												

IWPUT 0.0403

Specialty(s) Performing Procedure

57.6% PODIATRY
9.7% INTERNAL MEDICINE
9.4% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99344		XXX	3.38	AAFP, AAP	Total:	64,616		Feb07
					NF Total	16,499	Top NF INTERNAL MEDICINE	
					Fac Total		Top Fac	

Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	60	25	100												

IWPUT 0.0414

Specialty(s) Performing Procedure

25.5% INTERNAL MEDICINE
24.3% FAMILY PRACTICE
18.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99345		XXX	4.09	AAFP, AAP	Total:	70,094		Feb07
					NF Total	19,964	Top NF INTERNAL MEDICINE	
					Fac Total	1	Top Fac GERIATRIC MEDICINE	

Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	75	30	120												

IWPUT 0.0411

Specialty(s) Performing Procedure

28.5% INTERNAL MEDICINE
20.1% FAMILY PRACTICE
15.0% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99348		XXX	1.56	AAFP, APMA, AAP	Total:	573,847		Feb07
					NF Total	282,898	Top NF PODIATRY	
					Fac Total	5	Top Fac NURSE PRACTITIONERS	

Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
9	25	10	44												

IWPUT 0.0454

Specialty(s) Performing Procedure

49.3% PODIATRY
16.9% INTERNAL MEDICINE
12.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99349		XXX	2.33	AAFP, APMA, AAP	Total:	974,830		Feb07
					NF Total	306,499	Top NF INTERNAL MEDICINE	
					Fac Total	5	Top Fac FAMILY PRACTICE	

Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	40	15	65												

IWPUT 0.0443

Specialty(s) Performing Procedure

31.4% INTERNAL MEDICINE
24.4% FAMILY PRACTICE
13.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99350		XXX	3.28	AAFP, AAP	Total:	481,249		**Feb07**
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.					NF Total	130,899	Top NF INTERNAL MEDICINE	
					Fac Total	3	Top Fac FAMILY PRACTICE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	75	20	110												

IWPUT 0.0333

Specialty(s) Performing Procedure

27.2% INTERNAL MEDICINE
22.0% NURSE PRACTITIONERS
19.9% FAMILY PRACTICE

99406		XXX	0.24	ACCP/ATS, ACP	Total:	221,576		**April07**
Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes					NF Total	53,616	Top NF INTERNAL MEDICINE	
					Fac Total	11,471	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	7		7												

IWPUT 0.0343

Specialty(s) Performing Procedure

28.5% INTERNAL MEDICINE
21.9% FAMILY PRACTICE
13.6% CARDIOLOGY

99407		XXX	0.50	ACCP/ATS, ACP	Total:	53,661		**April07**
Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes					NF Total	15,511	Top NF INTERNAL MEDICINE	
					Fac Total	2,046	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0333

Specialty(s) Performing Procedure

32.7% INTERNAL MEDICINE
17.4% FAMILY PRACTICE
11.1% PULMONARY DISEASE

Multi-Specialty Points of Comparison (RVU Order)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92285		XXX	0.05	AAO, AOA (HCPAC)	Total:	305,350		**Yes Oct09**
External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)					NF Total	190,986	Top NF OPHTHALMOLOGY	
					Fac Total	6,496	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5		5												

IWPUT 0.0100

Specialty(s) Performing Procedure

64.7% OPHTHALMOLOGY
33.0% OPTOMETRY
1.6% PLASTIC AND RECONSTUCTIVE SURGERY

95165		XXX	0.06	AAO-HNS, JCAAI, AAOA	Total:	5,448,102		**Yes Feb06**	
Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)					NF Total	2,812,231	Top NF ALLERGY/IMMUNOLOGY		
					Fac Total	6,684	Top Fac ALLERGY/IMMUNOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	3		3												

IWPUT 0.0200

Specialty(s) Performing Procedure

51.7% ALLERGY/IMMUNOLOGY
34.1% OTOLARYNGOLOGY
5.1% INTERNAL MEDICINE

96153		XXX	0.10	APA, NASW	Total:	32,431		**Yes Feb01**	
Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)					NF Total	8,844	Top NF CLINICAL PSYCHOLOGIST		
					Fac Total	18,020	Top Fac CLINICAL PSYCHOLOGIST		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0184

Specialty(s) Performing Procedure

82.8% CLINICAL PSYCHOLOGIST
11.2% PSYCHIATRY
2.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96375		ZZZ	0.10	ACRh, ASH, ASCO	Total:	2,003,993		Yes Oct04
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)					NF Total	1,270,830	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	81	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3		4												

IWPUT 0.0259

Specialty(s) Performing Procedure

63.4% HEMATOLOGY/ONCOLOGY
21.4% MEDICAL ONCOLOGY
3.5% INTERNAL MEDICINE

90970		XXX	0.14	ASPN	Total:	1,313,833		Yes Feb08
End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older					NF Total	1,021,373	Top NF NEPHROLOGY	
					Fac Total	94,863	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	2.5		2												

IWPUT 0.0560

Specialty(s) Performing Procedure

85.0% NEPHROLOGY
10.7% INTERNAL MEDICINE
1.8% NURSE PRACTITIONERS

93042		XXX	0.15	ACEP, ACC	Total:	878,371		Yes Oct09
Rhythm ECG, 1-3 leads; interpretation and report only					NF Total	4,043	Top NF CARDIOLOGY	
					Fac Total	437,163	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	3	2	7												

IWPUT 0.0201

Specialty(s) Performing Procedure

49.8% EMERGENCY MEDICINE
28.7% CARDIOLOGY
11.1% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
73120		XXX	0.16	AAOS, ACR	Total:	271,925		**Yes**	**Aug05**
Radiologic examination, hand; 2 views					NF Total	62,283	Top NF RHEUMATOLOGY		
					Fac Total	66,243	Top Fac DIAGNOSTIC RADIOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0384

Specialty(s) Performing Procedure

35.1% DIAGNOSTIC RADIOLOGY
22.9% RHEUMATOLOGY
17.9% ORTHOPEDIC SURGERY

51741		XXX	0.17	AUA	Total:	631,519		**Yes**	**April10**
Complex uroflowmetry (eg, calibrated electronic equipment)					NF Total	528,130	Top NF UROLOGY		
					Fac Total	23,190	Top Fac UROLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5	2	7												

IWPUT 0.0250

Specialty(s) Performing Procedure

87.3% UROLOGY
7.6% OBSTETRICS/GYNECOLOGY
1.4% INTERNAL MEDICINE

93010		XXX	0.17	ACC	Total:	19,647,347		**Yes**	**Aug05**
Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only					NF Total	341,269	Top NF CARDIOLOGY		
					Fac Total	11,339,484	Top Fac CARDIOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	4	1	5												

IWPUT 0.0369

Specialty(s) Performing Procedure

59.5% CARDIOLOGY
19.8% INTERNAL MEDICINE
15.1% EMERGENCY MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96374		XXX	0.18	ACRh, ASH, ASCO	Total:	452,150		**Yes Oct04**
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug					NF Total	122,600	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	420	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	5	2	9												

IWPUT 0.0181

Specialty(s) Performing Procedure

27.1% HEMATOLOGY/ONCOLOGY
13.6% CARDIOLOGY
11.0% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99211		XXX	0.18	ANA, AAN, AOA, AAFP, ACP, ASCO, TES, ACRh, SGIM	Total:	8,360,950		**Yes Feb06**
Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.					NF Total	2,408,091	Top NF CARDIOLOGY	
					Fac Total	42,790	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5	2	7												

IWPUT 0.0270

Specialty(s) Performing Procedure

29.1% CARDIOLOGY
27.6% INTERNAL MEDICINE
18.3% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
71010		XXX	0.18	ACR	Total:	18,956,128		**Yes Aug05**
Radiologic examination, chest; single view, frontal					NF Total	823,851	Top NF PORTABLE XRAY SUPPLIER	
					Fac Total	16,815,058	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0451

Specialty(s) Performing Procedure

89.9% DIAGNOSTIC RADIOLOGY
5.3% PORTABLE XRAY SUPPLIER
2.2% INTERVENTIONAL RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96402		XXX	0.19	ASH, AUA	Total:	448,068		**Yes Oct04**
Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic					NF Total	320,150	Top NF UROLOGY	
					Fac Total	13	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	3	2	9												

IWPUT 0.0185

Specialty(s) Performing Procedure

71.5% UROLOGY
17.8% HEMATOLOGY/ONCOLOGY
6.0% MEDICAL ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96367		ZZZ	0.19	ASH, ASCO, IDSA	Total:	2,148,456		**Yes Oct04**
Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)					NF Total	1,455,881	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	10	Top Fac FAMILY PRACTICE	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	5		6												

IWPUT 0.0335

Specialty(s) Performing Procedure

67.8% HEMATOLOGY/ONCOLOGY
20.2% MEDICAL ONCOLOGY
3.3% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
70355		XXX	0.20	ADA/AAOMS	Total:	31,988		**Yes Aug05**
Orthopantogram (eg, panoramic x-ray)					NF Total	11,232	Top NF ORAL SURGERY	
					Fac Total	9,609	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	5	1	6												

IWPUT 0.0355

Specialty(s) Performing Procedure

40.6% ORAL SURGERY
30.4% DIAGNOSTIC RADIOLOGY
26.9% MAXILLOFACIAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96411		ZZZ	0.20	ASH, ASCO	Total:	295,505		**Yes Oct04**
Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)					NF Total	202,141	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	2	Top Fac HEMATOLOGY/ONCOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	4		7												

IWPUT 0.0332

Specialty(s) Performing Procedure

68.4% HEMATOLOGY/ONCOLOGY
22.7% MEDICAL ONCOLOGY
3.5% INTERNAL MEDICINE

92567		XXX	0.20	AAO-HNS, ASHA	Total:	654,991		**Yes April07**
Tympanometry (impedance testing)					NF Total	321,094	Top NF AUDIOLOGIST (IND.)	
					Fac Total	2,954	Top Fac AUDIOLOGIST (IND.)	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	4	1	6												

IWPUT 0.0388

Specialty(s) Performing Procedure

49.5% AUDIOLOGIST (IND.)
42.2% OTOLARYNGOLOGY
3.4% FAMILY PRACTICE

96521		XXX	0.21	ASCO	Total:	109,480		**Yes Oct04**
Refilling and maintenance of portable pump					NF Total	43,818	Top NF INFECTIOUS DISEASE	
					Fac Total	2	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	4	2	10												

IWPUT 0.0189

Specialty(s) Performing Procedure

40.0% INFECTIOUS DISEASE
37.0% HEMATOLOGY/ONCOLOGY
12.4% MEDICAL ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
96401		XXX	0.21	ASH, ASCO	Total:	319,343		Yes Oct04
	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic				NF Total	102,419	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	3	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	3	2	9												

IWPUT 0.0252

Specialty(s) Performing Procedure

32.1% HEMATOLOGY/ONCOLOGY
26.1% RHEUMATOLOGY
8.0% ALLERGY/IMMUNOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88304		XXX	0.22	CAP, AAD	Total:	1,103,248		Yes April10
	Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pathologic fracture, Bursa/synovial cyst, Carpal tunnel tissue, Cartilage, shavings, Cholesteatoma Colon, colostomy stoma, Conjunctiva - biopsy/pterygium, Cornea Diverticulum - esophagus/small intestine, Dupuytren's contracture tissue, Femoral head, other than fracture, Fissure/fistula, Foreskin, other than newborn, Gallbladder, Ganglion cyst, Hematoma, Hemorrhoids, Hydatid of Morgagni, Intervertebral disc, Joint, loose body, Meniscus Mucocele, salivary, Neuroma - Morton's/traumatic, Pilonidal cyst/sinus, Polyps, inflammatory - nasal/sinusoidal, Skin - cyst/tag/debridement, Soft tissue, debridement, Soft tissue, lipoma, Spermatocele, Tendon/tendon sheath, Testicular appendage, Thrombus or embolus, Tonsil and/or adenoids, Varicocele, Vas deferens, other than sterilization, Vein, varicosity				NF Total	175,839	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	731,169	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0147

Specialty(s) Performing Procedure

78.1% PATHOLOGY
16.7% CLINICAL LABORATORY (IND.
4.1% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
71020		XXX	0.22	ACR	Total:	13,329,285		Yes Aug05
Radiologic examination, chest, 2 views, frontal and lateral;					NF Total	1,721,776	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	9,205,907	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0584

Specialty(s) Performing Procedure

82.0% DIAGNOSTIC RADIOLOGY
4.3% INTERNAL MEDICINE
4.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99406		XXX	0.24	ACCP/ATS, ACP	Total:	221,576		Yes April07
Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes					NF Total	53,616	Top NF INTERNAL MEDICINE	
					Fac Total	11,471	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	7		7												

IWPUT 0.0343

Specialty(s) Performing Procedure

28.5% INTERNAL MEDICINE
21.9% FAMILY PRACTICE
13.6% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93922		XXX	0.25	ACR, ACC, SVS	Total:	611,045		Yes April10
Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)					NF Total	105,459	Top NF CARDIOLOGY	
					Fac Total	52,790	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	5	2	10												

IWPUT 0.0276

Specialty(s) Performing Procedure

19.2% CARDIOLOGY
19.2% VASCULAR SURGERY
15.2% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
74020		XXX	0.27	ACR	Total:	797,903		**Yes Aug05**
Radiologic examination, abdomen; complete, including decubitus and/or erect views					NF Total	41,314	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	693,001	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	3	1	5												

IWPUT 0.0751

Specialty(s) Performing Procedure

92.0% DIAGNOSTIC RADIOLOGY
2.2% INTERVENTIONAL RADIOLOGY
1.8% FAMILY PRACTICE

96413		XXX	0.28	ACRh, ASH, ASCO, AGA	Total:	2,289,174		**Yes Oct04**
Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug					NF Total	1,281,676	Top NF HEMATOLOGY/ONCOLOGY	
					Fac Total	2	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	7	2	13												

IWPUT 0.0208

Specialty(s) Performing Procedure

56.0% HEMATOLOGY/ONCOLOGY
17.9% MEDICAL ONCOLOGY
13.5% RHEUMATOLOGY

90969		XXX	0.29	ASPN	Total:	11,267		**Yes Feb08**
End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age					NF Total	3,802	Top NF NEPHROLOGY	
					Fac Total	4,576	Top Fac PEDIATRIC MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	7.27		7												

IWPUT 0.0399

Specialty(s) Performing Procedure

50.3% PEDIATRIC MEDICINE
46.0% NEPHROLOGY
1.4% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92568		XXX	0.29	AAO-HNS, ASHA	Total:	73,776		Yes April07
Acoustic reflex testing, threshold					NF Total	34,938	Top NF OTOLARYNGOLOGY	
					Fac Total	3,387	Top Fac AUDIOLOGIST (IND.)	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
1	8	1	10												

IWPUT 0.0306

Specialty(s) Performing Procedure

47.4% OTOLARYNGOLOGY
39.6% AUDIOLOGIST (IND.)
4.6% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92081		XXX	0.30	AAO	Total:	117,269		Yes April10
Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)					NF Total	61,431	Top NF OPHTHALMOLOGY	
					Fac Total	1,468	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	7		10												

IWPUT 0.0333

Specialty(s) Performing Procedure

53.6% OPHTHALMOLOGY
41.8% OPTOMETRY
1.8% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92025		XXX	0.35	AAO, AOA(HCPAC)	Total:	107,320		Yes Feb06
Computerized corneal topography, unilateral or bilateral, with interpretation and report					NF Total	88,890	Top NF OPHTHALMOLOGY	
					Fac Total	3,550	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	12		17												

IWPUT 0.0198

Specialty(s) Performing Procedure

86.1% OPHTHALMOLOGY
13.6% OPTOMETRY
0.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95874		ZZZ	0.37	AAN, AANEM, AAPM&R	Total:	52,023		Yes April05
Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)					NF Total	23,537	Top NF NEUROLOGY	
					Fac Total	6,068	Top Fac NEUROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	20		20												

IWPUT 0.0185

Specialty(s) Performing Procedure

56.9% NEUROLOGY
31.3% PHYSICAL MEDICINE AND REHABILITATION
8.3% OTOLARYNGOLOGY

77421		XXX	0.39	ASTRO	Total:	1,140,462		Yes	April05
Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy					NF Total	647,950	Top NF RADIATION ONCOLOGY		
					Fac Total	428,417	Top Fac RADIATION ONCOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	9		9												

IWPUT 0.0433

Specialty(s) Performing Procedure

94.4% RADIATION ONCOLOGY
4.0% DIAGNOSTIC RADIOLOGY
0.7% RADIATION THERAPY CENTERS

29540		000	0.39	APMA	Total:	301,288		Yes	April10
Strapping; ankle and/or foot					NF Total	262,389	Top NF PODIATRY		
					Fac Total	2,197	Top Fac PODIATRY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	9	2	18												

IWPUT 0.0209

Specialty(s) Performing Procedure

87.8% PODIATRY
4.3% PHYSICAL THERAPIST (IND.)
2.5% PHYSICAL MEDICINE AND REHABILITATION

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92082		XXX	0.40	AAO	Total:	176,773		Yes April10
	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)				NF Total	98,086	Top NF OPHTHALMOLOGY	
					Fac Total	3,565	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	8		11												

IWPUT 0.0416

Specialty(s) Performing Procedure

57.5% OPHTHALMOLOGY
40.8% OPTOMETRY
0.8% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92250		XXX	0.44	AAO, AOA (HCPAC)	Total:	2,162,922		Yes Aug05
	Fundus photography with interpretation and report				NF Total	1,279,855	Top NF OPHTHALMOLOGY	
					Fac Total	23,580	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	9	5	14												

IWPUT 0.0364

Specialty(s) Performing Procedure

60.3% OPHTHALMOLOGY
39.2% OPTOMETRY
0.1% ENDOCRINOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99281		XXX	0.45	ACEP	Total:	81,426		Yes Sept05
	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.				NF Total	3	Top NF GENERAL PRACTICE	
					Fac Total	40,744	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	7	4	13												

IWPUT 0.0451

Specialty(s) Performing Procedure

50.0% EMERGENCY MEDICINE
13.0% FAMILY PRACTICE
10.9% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93923		XXX	0.45	ACR, ACC, SVS	Total:	633,077		Yes April10
					NF Total	103,658	Top NF CARDIOLOGY	
					Fac Total	70,502	Top Fac DIAGNOSTIC RADIOLOGY	

Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	10	3	16												

IWPUT 0.0316

Specialty(s) Performing Procedure

25.6% VASCULAR SURGERY
18.8% CARDIOLOGY
15.0% DIAGNOSTIC RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99212		XXX	0.48	ANA, AAN, AOA, AAFP, ACP, TES, ACRh, ASCO, SGIM	Total:	19,056,063		Yes Feb06
					NF Total	2,463,694	Top NF DERMATOLOGY	
					Fac Total	168,351	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	10	4	16												

IWPUT 0.0346

Specialty(s) Performing Procedure

13.2% DERMATOLOGY
12.9% PODIATRY
10.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99407		XXX	0.50	ACCP/ATS, ACP	Total:	53,661		**Yes April07**
Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes					NF Total	15,511	Top NF INTERNAL MEDICINE	
					Fac Total	2,046	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0333

Specialty(s) Performing Procedure

32.7% INTERNAL MEDICINE
17.4% FAMILY PRACTICE
11.1% PULMONARY DISEASE

51702		000	0.50	AUA	Total:	202,781		**Yes April02**
Insertion of temporary indwelling bladder catheter; simple (eg, Foley)					NF Total	145,355	Top NF UROLOGY	
					Fac Total	15,125	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	8		8												

IWPUT 0.0625

Specialty(s) Performing Procedure

77.9% UROLOGY
7.8% EMERGENCY MEDICINE
3.4% PHYSICIANS ASSISTANT

93224		XXX	0.52	ACC	Total:	221,981		**Yes April10**
External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation					NF Total	175,178	Top NF CARDIOLOGY	
					Fac Total	46	Top Fac INDEPENDENT DIAGNOSTIC TESTING	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	15	7	24												

IWPUT 0.0212

Specialty(s) Performing Procedure

78.9% CARDIOLOGY
13.8% INTERNAL MEDICINE
3.7% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76519		XXX	0.54	AAO	Total:	619,641		**Yes Aug05**
Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation					NF Total	576,698	Top NF OPHTHALMOLOGY	
					Fac Total	28,584	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
12	5		17												

IWPUT 0.0542

Specialty(s) Performing Procedure

97.7% OPHTHALMOLOGY
1.9% OPTOMETRY
0.2% OTOLARYNGOLOGY

46600		000	0.55	ASCRS, ACS	Total:	96,854		**Yes Feb07**
Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)					NF Total	41,108	Top NF COLORECTAL SURGERY(FORMERLY P	
					Fac Total	2,690	Top Fac COLORECTAL SURGERY(FORMERLY P	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	5	10	22												

IWPUT 0.0338

Specialty(s) Performing Procedure

45.2% COLORECTAL SURGERY(FORMERLY PROCTOLOGY)
22.6% GENERAL SURGERY
10.6% FAMILY PRACTICE

76536		XXX	0.56	ACR, ASNR, TES, AACE	Total:	592,261		**Yes April09**
Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation					NF Total	144,918	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	257,412	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	10	4	18												

IWPUT 0.0381

Specialty(s) Performing Procedure

67.9% DIAGNOSTIC RADIOLOGY
14.7% ENDOCRINOLOGY
5.4% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
69210		000	0.61	AAO-HNS	Total:	1,412,292		**Yes Sept05**
Removal impacted cerumen (separate procedure), 1 or both ears					NF Total	592,968	Top NF OTOLARYNGOLOGY	
					Fac Total	29,632	Top Fac OTOLARYNGOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	2	19												

IWPUT 0.0408

Specialty(s) Performing Procedure

44.1% OTOLARYNGOLOGY
22.1% FAMILY PRACTICE
20.0% INTERNAL MEDICINE

17000		010	0.65	AAD, AAFP	Total:	4,800,111		**Yes Aug05**
Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion					NF Total	3,841,634	Top NF DERMATOLOGY	
					Fac Total	85,836	Top Fac DERMATOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	3	2	25									1			

IWPUT 0.0119

Specialty(s) Performing Procedure

81.8% DERMATOLOGY
5.8% FAMILY PRACTICE
4.6% PHYSICIANS ASSISTANT

76815		XXX	0.65	ACOG, ACR	Total:	13,623		**Yes April02**
Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses					NF Total	4,046	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	5,747	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	5.5	5	16												

IWPUT 0.0774

Specialty(s) Performing Procedure

48.5% OBSTETRICS/GYNECOLOGY
44.7% DIAGNOSTIC RADIOLOGY
2.6% EMERGENCY MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
20552		000	0.66	AAN, AAOS, APMA, AAPMR, ACRh, AOFAS	Total:	294,594		Yes April02
Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)					NF Total	47,889	Top NF PHYSICAL MEDICINE AND REHABILITA	
					Fac Total	15,862	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	5	3.5	14												

IWPUT 0.0939

Specialty(s) Performing Procedure

17.4% PHYSICAL MEDICINE AND REHABILITATION
14.1% ORTHOPEDIC SURGERY
12.7% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
67820		000	0.71	AAO, AOA(HCPAC)	Total:	332,209		Yes Aug05
Correction of trichiasis; epilation, by forceps only					NF Total	226,448	Top NF OPHTHALMOLOGY	
					Fac Total	3,168	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	5	2	15												

IWPUT 0.1001

Specialty(s) Performing Procedure

69.1% OPHTHALMOLOGY
30.5% OPTOMETRY
0.1% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76817		XXX	0.75	ACOG, ACR	Total:	15,358		Yes April02
Ultrasound, pregnant uterus, real time with image documentation, transvaginal					NF Total	5,961	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	6,379	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	8	23												

IWPUT 0.0459

Specialty(s) Performing Procedure

50.9% OBSTETRICS/GYNECOLOGY
45.3% DIAGNOSTIC RADIOLOGY
0.7% INTERVENTIONAL RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
20553		000	0.75	AAN, AAOS, APMA, AAPMR, ACRh, AOFAS	Total:	165,881		Yes April02
Injection(s); single or multiple trigger point(s), 3 or more muscle(s)					NF Total	39,337	Top NF PHYSICAL MEDICINE AND REHABILITA	
					Fac Total	8,581	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	5	22												

IWPUT 0.0481

Specialty(s) Performing Procedure

25.5% PHYSICAL MEDICINE AND REHABILITATION
15.4% ANESTHESIOLOGY
11.8% INTERVENTIONAL PAIN MANAGEMENT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
93015		XXX	0.75	ACC	Total:	1,711,584		Yes Aug05
Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report					NF Total	1,502,149	Top NF CARDIOLOGY	
					Fac Total	16	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	15	4	21												

IWPUT 0.0410

Specialty(s) Performing Procedure

87.8% CARDIOLOGY
7.6% INTERNAL MEDICINE
1.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88305		XXX	0.75	CAP, AAD	Total:	16,231,440		Yes April10
					NF Total	4,540,988	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	5,811,292	Top Fac PATHOLOGY	

Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of surgical margins, Breast, reduction mammoplasty, Bronchus, biopsy, Cell block, any source, Cervix, biopsy, Colon, biopsy, Duodenum, biopsy, Endocervix, curettings/biopsy, Endometrium, curettings/biopsy, Esophagus, biopsy, Extremity, amputation, traumatic, Fallopian tube, biopsy, Fallopian tube, ectopic pregnancy, Femoral head, fracture, Fingers/toes, amputation, non-traumatic, Gingiva/oral mucosa, biopsy, Heart valve, Joint, resection, Kidney, biopsy, Larynx, biopsy, Leiomyoma(s), uterine myomectomy - without uterus, Lip, biopsy/wedge resection, Lung, transbronchial biopsy, Lymph node, biopsy, Muscle, biopsy, Nasal mucosa, biopsy, Nasopharynx/oropharynx, biopsy, Nerve, biopsy, Odontogenic/dental cyst, Omentum, biopsy, Ovary with or without tube, non-neoplastic, Ovary, biopsy/wedge resection, Parathyroid gland, Peritoneum, biopsy, Pituitary tumor, Placenta, other than third trimester, Pleura/pericardium - biopsy/tissue, Polyp, cervical/endometrial, Polyp, colorectal, Polyp, stomach/small intestine, Prostate, needle biopsy, Prostate, TUR, Salivary gland, biopsy, Sinus, paranasal biopsy, Skin, other than cyst/tag/debridement/plastic repair, Small intestine, biopsy, Soft tissue, other than tumor/mass/lipoma/debridement, Spleen, Stomach, biopsy, Synovium, Testis, other than tumor/biopsy/castration, Thyroglossal duct/brachial cleft cyst, Tongue, biopsy, Tonsil, biopsy, Trachea, biopsy, Ureter, biopsy, Urethra, biopsy, Urinary bladder, biopsy, Uterus, with or without tubes and ovaries, for prolapse, Vagina, biopsy, Vulva/labia, biopsy

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	25		25												

IWPUT 0.0300

Specialty(s) Performing Procedure

58.2% PATHOLOGY
28.3% CLINICAL LABORATORY (IND.
12.0% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99231		XXX	0.76	IDSA, AAN, AOA, AAFP, ACP, TES, SGIM	Total:	13,056,708		Yes Feb06
					NF Total	57	Top NF INTERNAL MEDICINE	
					Fac Total	2,908,856	Top Fac INTERNAL MEDICINE	

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	5	20												

IWPUT 0.0536

Specialty(s) Performing Procedure

22.3% INTERNAL MEDICINE
9.6% PSYCHIATRY
8.1% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95991		XXX	0.77	AAPM, ASA, AANS, CNS	Total:	88,496		Yes Feb03
					NF Total	20,613	Top NF ANESTHESIOLOGY	
					Fac Total	9,419	Top Fac ANESTHESIOLOGY	

Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	7	37												

IWPUT 0.0195

Specialty(s) Performing Procedure

33.9% ANESTHESIOLOGY
25.9% INTERVENTIONAL PAIN MANAGEMENT
15.6% PHYSICAL MEDICINE AND REHABILITATION

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95971		XXX	0.78	AANS, AAPM, ASA	Total:	26,356		Yes April04
					NF Total	11,245	Top NF UROLOGY	
					Fac Total	754	Top Fac ANESTHESIOLOGY	

Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	20	3	26												

IWPUT 0.0323

Specialty(s) Performing Procedure

43.7% UROLOGY
24.4% OBSTETRICS/GYNECOLOGY
7.8% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15003		ZZZ	0.80	ABA, ACS, ASPS	Total:	34,973		Yes April06
					NF Total	47	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	19,742	Top Fac GENERAL SURGERY	

Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15	1	16												

IWPUT 0.0518

Specialty(s) Performing Procedure

56.5% GENERAL SURGERY
36.7% PLASTIC AND RECONSTUCTIVE SURGERY
3.7% CRITICAL CARE (INTENSIVISTS)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
45300		000	0.80	ASCRS, ACS	Total:	41,863		Yes Feb07
					NF Total	24,611	Top NF COLORECTAL SURGERY(FORMERLY P	
					Fac Total	4,150	Top Fac GENERAL SURGERY	

Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	10	27												

IWPUT 0.0419

Specialty(s) Performing Procedure

65.1% COLORECTAL SURGERY(FORMERLY PROCTOLOGY)
24.2% GENERAL SURGERY
3.8% GASTROENTEROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
51797		ZZZ	0.80	AUA	Total:	156,207		Yes April09
Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)					NF Total	99,137	Top NF UROLOGY	
					Fac Total	12,328	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0533

Specialty(s) Performing Procedure

71.4% UROLOGY
22.5% OBSTETRICS/GYNECOLOGY
1.8% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76700		XXX	0.81	ACR	Total:	1,040,905		Yes Aug05
Ultrasound, abdominal, real time with image documentation; complete					NF Total	239,697	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	584,744	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	10	4	17												

IWPUT 0.0653

Specialty(s) Performing Procedure

79.2% DIAGNOSTIC RADIOLOGY
5.8% INDEPENDENT DIAGNOSTIC TESTING FACILITY
5.6% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11100		000	0.81	AAD	Total:	2,702,008		Yes Aug05
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion					NF Total	2,222,866	Top NF DERMATOLOGY	
					Fac Total	59,140	Top Fac DERMATOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	12	5	22												

IWPUT 0.0488

Specialty(s) Performing Procedure

84.5% DERMATOLOGY
5.4% PHYSICIANS ASSISTANT
2.5% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12001		000	0.84	ACEP, AAFP	Total:	179,272		Yes April10
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less					NF Total	18,260	Top NF FAMILY PRACTICE	
					Fac Total	85,187	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	5	22												

IWPUT 0.0586

Specialty(s) Performing Procedure

50.1% EMERGENCY MEDICINE
15.8% FAMILY PRACTICE
15.2% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76816		XXX	0.85	ACOG, ACR	Total:	14,036		Yes April02
Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus					NF Total	7,497	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	4,362	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
6	15	10	31												

IWPUT 0.0328

Specialty(s) Performing Procedure

84.5% OBSTETRICS/GYNECOLOGY
12.8% DIAGNOSTIC RADIOLOGY
0.4% GYNECOLOGY/ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95251		XXX	0.85	AACE	Total:	21,040		Yes Feb05
Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report					NF Total	10,590	Top NF ENDOCRINOLOGY	
					Fac Total	492	Top Fac ENDOCRINOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	30		30												

IWPUT 0.0283

Specialty(s) Performing Procedure

52.7% ENDOCRINOLOGY
28.3% INTERNAL MEDICINE
10.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
78306		XXX	0.86	SNM, ACR	Total:	412,804		**Yes Aug05**
Bone and/or joint imaging; whole body					NF Total	52,776	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	293,807	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	8	5	18												

IWPUT 0.0795

Specialty(s) Performing Procedure

84.0% DIAGNOSTIC RADIOLOGY
10.8% NUCLEAR MEDICINE
1.6% INTERVENTIONAL RADIOLOGY

92002		XXX	0.88	AAO, AOA(HCPAC)	Total:	216,904		**Yes Feb07**
Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient					NF Total	113,341	Top NF OPHTHALMOLOGY	
					Fac Total	6,162	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	15	5	25												

IWPUT 0.0437

Specialty(s) Performing Procedure

55.1% OPHTHALMOLOGY
44.4% OPTOMETRY
0.1% PLASTIC AND RECONSTUCTIVE SURGERY

99282		XXX	0.88	ACEP	Total:	533,649		**Yes Sept05**
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.					NF Total	1	Top NF GENERAL PRACTICE	
					Fac Total	309,836	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	10	5	18												

IWPUT 0.0701

Specialty(s) Performing Procedure

58.1% EMERGENCY MEDICINE
12.6% FAMILY PRACTICE
11.5% PHYSICIANS ASSISTANT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11400		010	0.90	AAD	Total:	43,795		**Yes Aug05**
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less					NF Total	14,757	Top NF DERMATOLOGY	
					Fac Total	1,713	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	5	36									1			

IWPUT 0.0196

Specialty(s) Performing Procedure

34.4% DERMATOLOGY
27.1% FAMILY PRACTICE
11.6% GENERAL SURGERY

43760		000	0.90	AGA, ASGE	Total:	59,752		**Yes April07**
Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance					NF Total	2,585	Top NF GENERAL SURGERY	
					Fac Total	20,108	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
17	10	5	32												

IWPUT 0.0436

Specialty(s) Performing Procedure

33.7% EMERGENCY MEDICINE
33.3% GASTROENTEROLOGY
14.1% GENERAL SURGERY

92012		XXX	0.92	AAO, AOA(HCPAC)	Total:	6,697,588		**Yes Feb07**
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient					NF Total	5,489,252	Top NF OPHTHALMOLOGY	
					Fac Total	123,147	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	15	5	25												

IWPUT 0.0464

Specialty(s) Performing Procedure

83.8% OPHTHALMOLOGY
15.9% OPTOMETRY
0.1% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99202		XXX	0.93	AAD, APMA, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	3,074,347		Yes Feb06
					NF Total	723,275	Top NF DERMATOLOGY	
					Fac Total	27,010	Top Fac DERMATOLOGY	

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
2	15	5	22												

IWPUT 0.0516

Specialty(s) Performing Procedure

24.4% DERMATOLOGY
17.2% PODIATRY
8.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99213		XXX	0.97	ANA, ASCO, ACRh, AAN, AOA, AAFP, TES, ACP, SGIM	Total:	100,611,197		Yes Feb06
					NF Total	21,684,587	Top NF INTERNAL MEDICINE	
					Fac Total	1,365,234	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	15	5	23												

IWPUT 0.0527

Specialty(s) Performing Procedure

22.9% INTERNAL MEDICINE
19.7% FAMILY PRACTICE
6.3% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
76805		XXX	0.99	ACOG, ACR	Total:	12,521		Yes April02
Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation					NF Total	5,353	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	3,783	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	15	6	26												

IWPUT 0.0496

Specialty(s) Performing Procedure

58.4% OBSTETRICS/GYNECOLOGY
37.2% DIAGNOSTIC RADIOLOGY
1.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64484		ZZZ	1.00	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	422,276		Yes Oct09
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)					NF Total	69,293	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	66,023	Top Fac INTERVENTIONAL PAIN MANAGEMENT	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	10		10												

IWPUT 0.1000

Specialty(s) Performing Procedure

32.0% INTERVENTIONAL PAIN MANAGEMENT
26.6% ANESTHESIOLOGY
17.4% PHYSICAL MEDICINE AND REHABILITATION

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
94004		XXX	1.00	AAP, ASA, ACCP/ATS	Total:	38,078		Yes April06
Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day					NF Total	3,666	Top NF PULMONARY DISEASE	
					Fac Total	20,802	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	15	10	35												

IWPUT 0.0368

Specialty(s) Performing Procedure

64.3% PULMONARY DISEASE
21.2% INTERNAL MEDICINE
6.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11042		000	1.01	APMA, ACS	Total:	1,290,599		Yes Feb10
Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less					NF Total	327,278	Top NF PODIATRY	
					Fac Total	179,604	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
11	15	10	36												

IWPUT 0.0369

Specialty(s) Performing Procedure

36.8% PODIATRY
17.6% GENERAL SURGERY
8.8% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11440		010	1.05	AAD	Total:	49,087		Yes Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less					NF Total	12,434	Top NF OPHTHALMOLOGY	
					Fac Total	2,008	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	10	5	36									1			

IWPUT 0.0346

Specialty(s) Performing Procedure

29.4% OPHTHALMOLOGY
25.9% DERMATOLOGY
12.4% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12011		000	1.07	ACEP, AAFP	Total:	88,270		Yes April10
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less					NF Total	4,015	Top NF FAMILY PRACTICE	
					Fac Total	53,647	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	12	5	24												

IWPUT 0.0680

Specialty(s) Performing Procedure

62.1% EMERGENCY MEDICINE
13.2% PHYSICIANS ASSISTANT
9.8% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
30901		000	1.10	AAO-HNS	Total:	115,779		**Yes April10**
Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method					NF Total	47,219	Top NF OTOLARYNGOLOGY	
					Fac Total	42,986	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
11	10	5	26												

IWPUT 0.0813

Specialty(s) Performing Procedure

44.4% OTOLARYNGOLOGY
37.7% EMERGENCY MEDICINE
6.2% FAMILY PRACTICE

12002		000	1.14	ACEP, AAFP	Total:	139,131		**Yes April10**
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm					NF Total	11,425	Top NF FAMILY PRACTICE	
					Fac Total	74,047	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	15	5	27												

IWPUT 0.0590

Specialty(s) Performing Procedure

55.5% EMERGENCY MEDICINE
13.7% FAMILY PRACTICE
13.7% PHYSICIANS ASSISTANT

36620		000	1.15	ASA	Total:	565,857		**Yes April07**
Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous					NF Total	191	Top NF PULMONARY DISEASE	
					Fac Total	461,285	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	10	5	22												

IWPUT 0.0924

Specialty(s) Performing Procedure

81.5% ANESTHESIOLOGY
6.8% CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)
2.7% PULMONARY DISEASE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99308		XXX	1.16	AGA	Total:	9,319,037		Yes Feb07
					NF Total	1,256,751	Top NF INTERNAL MEDICINE	
					Fac Total	2,000,744	Top Fac INTERNAL MEDICINE	

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	15	9	31												

IWPUT 0.0534

Specialty(s) Performing Procedure

35.0% INTERNAL MEDICINE
19.6% FAMILY PRACTICE
19.2% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88361		XXX	1.18	CAP, ASC	Total:	150,498		Yes Oct04
					NF Total	38,288	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	59,287	Top Fac PATHOLOGY	

Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	40		40												

IWPUT 0.0295

Specialty(s) Performing Procedure

53.4% PATHOLOGY
26.6% CLINICAL LABORATORY (IND.
15.6% HEMATOLOGY/ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88112		XXX	1.18	CAP	Total:	937,311		Yes April03
Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal					NF Total	254,533	Top NF PATHOLOGY	
					Fac Total	418,366	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	25	10	43												

IWPUT 0.0311

Specialty(s) Performing Procedure

71.8% PATHOLOGY
23.8% CLINICAL LABORATORY (IND.
4.0% UROLOGY

95805		XXX	1.20	AAN, AASM, ACNS, ACCP/ATS	Total:	7,559		Yes April10
Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness					NF Total	1,308	Top NF NEUROLOGY	
					Fac Total	1,649	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	15	50												

IWPUT 0.0264

Specialty(s) Performing Procedure

38.0% PULMONARY DISEASE
26.6% NEUROLOGY
11.7% INTERNAL MEDICINE

64480		ZZZ	1.20	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	32,822		Yes Oct09
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)					NF Total	4,769	Top NF NEUROSURGERY	
					Fac Total	4,243	Top Fac INTERVENTIONAL PAIN MANAGEMENT	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	15		15												

IWPUT 0.0800

Specialty(s) Performing Procedure

25.5% INTERVENTIONAL PAIN MANAGEMENT
20.4% ANESTHESIOLOGY
16.2% PAIN MANAGEMENT

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
10060		010	1.22	APMA, ACS	Total:	526,284		**Yes Sept05**
Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single					NF Total	249,183	Top NF PODIATRY	
					Fac Total	20,060	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
16	15	10	57									1			

IWPUT 0.0153

Specialty(s) Performing Procedure

49.6% PODIATRY
12.5% FAMILY PRACTICE
11.9% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12013		000	1.22	ACEP, AAFP	Total:	50,284		**Yes April10**
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm					NF Total	2,010	Top NF FAMILY PRACTICE	
					Fac Total	32,691	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	15	5	27												

IWPUT 0.0644

Specialty(s) Performing Procedure

66.2% EMERGENCY MEDICINE
11.6% PHYSICIANS ASSISTANT
9.6% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92604		XXX	1.25	AAO-HNS, ASHA	Total:	11,467		**Yes April07**
Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming					NF Total	7,623	Top NF AUDIOLOGIST (IND.)	
					Fac Total	297	Top Fac AUDIOLOGIST (IND.)	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	50	10	65												

IWPUT 0.0183

Specialty(s) Performing Procedure

69.1% AUDIOLOGIST (IND.)
29.6% OTOLARYNGOLOGY
0.7% THORACIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99238		XXX	1.28	AOA, AAFP, ACP, SGIM	Total:	4,979,896		Yes Feb06
Hospital discharge day management; 30 minutes or less					NF Total	4	Top NF INTERNAL MEDICINE	
					Fac Total	2,541,864	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	20	10	38												

IWPUT 0.0438

Specialty(s) Performing Procedure

51.0% INTERNAL MEDICINE
17.5% FAMILY PRACTICE
7.5% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88367		XXX	1.30	CAP, ASC	Total:	503,924		Yes Oct09
Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology					NF Total	248,924	Top NF PATHOLOGY	
					Fac Total	20,679	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	42		42												

IWPUT 0.0310

Specialty(s) Performing Procedure

53.5% PATHOLOGY
26.5% CLINICAL LABORATORY (IND.
19.8% UROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99283		XXX	1.34	ACEP	Total:	3,833,077		Yes Sept05
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.					NF Total	1	Top NF GASTROENTEROLOGY	
					Fac Total	2,529,043	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	18	7	30												

IWPUT 0.0595

Specialty(s) Performing Procedure

66.0% EMERGENCY MEDICINE
12.1% PHYSICIANS ASSISTANT
8.2% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
94003		XXX	1.37	AAP, ASA, ACCP/ATS	Total:	150,170		**Yes April06**
Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day					NF Total	38	Top NF PULMONARY DISEASE	
					Fac Total	107,251	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	10	40												

IWPUT 0.0461

Specialty(s) Performing Procedure

71.4% PULMONARY DISEASE
12.4% INTERNAL MEDICINE
6.8% CRITICAL CARE (INTENSIVISTS)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99232		XXX	1.39	IDSA, AAN, AOA, AAFP, ACP, TES, SGIM,	Total:	50,265,347		**Yes Feb06**
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.					NF Total	166	Top NF INTERNAL MEDICINE	
					Fac Total	18,139,210	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	10	40												

IWPUT 0.0471

Specialty(s) Performing Procedure

36.1% INTERNAL MEDICINE
10.7% CARDIOLOGY
7.5% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99203		XXX	1.42	APMA, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	9,033,718		**Yes Feb06**
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.					NF Total Fac Total	1,297,924 65,719	Top NF ORTHOPEDIC SURGERY Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	20	5	29												

IWPUT 0.0609

Specialty(s) Performing Procedure

15.1% ORTHOPEDIC SURGERY
11.2% PODIATRY
9.5% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92014		XXX	1.42	AAO, AOA(HCPAC)	Total:	10,940,913		**Yes Feb07**
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits					NF Total Fac Total	8,000,829 159,188	Top NF OPHTHALMOLOGY Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	24	8	37												

IWPUT 0.0470

Specialty(s) Performing Procedure

74.6% OPHTHALMOLOGY
25.2% OPTOMETRY
0.1% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12004		000	1.44	ACEP, AAFP	Total:	21,241		**Yes April10**
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm					NF Total Fac Total	1,390 11,909	Top NF FAMILY PRACTICE Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	17	5	29												

IWPUT 0.0697

Specialty(s) Performing Procedure

57.9% EMERGENCY MEDICINE
12.5% PHYSICIANS ASSISTANT
12.2% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11402		010	1.45	AAD	Total:	117,444		Yes Aug05
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm					NF Total	54,334	Top NF DERMATOLOGY	
					Fac Total	9,015	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	5	56									1			

IWPUT 0.0254

Specialty(s) Performing Procedure

47.5% DERMATOLOGY
20.5% GENERAL SURGERY
13.2% FAMILY PRACTICE

90935		000	1.48	RPA	Total:	1,367,649		Yes Oct09
Hemodialysis procedure with single physician evaluation					NF Total	7,986	Top NF NEPHROLOGY	
					Fac Total	1,154,216	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	10	45												

IWPUT 0.0413

Specialty(s) Performing Procedure

85.0% NEPHROLOGY
12.2% INTERNAL MEDICINE
0.9% NEUROLOGY

99214		XXX	1.50	ANA, ASCO,ACRh, AAN, AOA, AAFP, TES, ACP, SGIM	Total:	78,471,611		Yes Feb06
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.					NF Total	19,538,174	Top NF INTERNAL MEDICINE	
					Fac Total	1,521,069	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	25	10	40												

IWPUT 0.0466

Specialty(s) Performing Procedure

26.8% INTERNAL MEDICINE
21.1% FAMILY PRACTICE
11.1% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
57452		000	1.50	ACOG, AUGS	Total:	10,829		Yes April02
Colposcopy of the cervix including upper/adjacent vagina;					NF Total	6,670	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	791	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	15	10	40												

IWPUT 0.0627

Specialty(s) Performing Procedure

68.9% OBSTETRICS/GYNECOLOGY
14.4% GYNECOLOGY/ONCOLOGY
10.1% UROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95972		XXX	1.50	AANS, AAPM, ASA	Total:	57,891		Yes April04
Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour					NF Total	11,095	Top NF UROLOGY	
					Fac Total	5,901	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
3	60	5	68												

IWPUT 0.0220

Specialty(s) Performing Procedure

29.4% UROLOGY
20.2% INTERVENTIONAL PAIN MANAGEMENT
17.6% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11441		010	1.53	AAO-HNS, AAD	Total:	55,270		Yes Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm					NF Total	19,255	Top NF DERMATOLOGY	
					Fac Total	2,888	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits				Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	20	5	51									1			

IWPUT 0.0357

Specialty(s) Performing Procedure

35.5% DERMATOLOGY
16.3% PLASTIC AND RECONSTUCTIVE SURGERY
11.0% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95861		XXX	1.54	AANEM, AAN, AAPMR	Total:	374,908		**Yes Aug05**
Needle electromyography; 2 extremities with or without related paraspinal areas					NF Total	191,592	Top NF NEUROLOGY	
					Fac Total	44,453	Top Fac NEUROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	25	10	50												

IWPUT 0.0392

Specialty(s) Performing Procedure

63.0% NEUROLOGY
26.6% PHYSICAL MEDICINE AND REHABILITATION
2.3% INTERNAL MEDICINE

99309		XXX	1.55	AGA	Total:	6,686,008		**Yes Feb07**
Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.					NF Total	835,683	Top NF INTERNAL MEDICINE	
					Fac Total	1,376,960	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	10	45												

IWPUT 0.0441

Specialty(s) Performing Procedure

33.1% INTERNAL MEDICINE
23.7% NURSE PRACTITIONERS
17.9% FAMILY PRACTICE

90945		000	1.56	RPA	Total:	127,219		**Yes Oct09**
Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation					NF Total	643	Top NF NEPHROLOGY	
					Fac Total	109,818	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	27	10	47												

IWPUT 0.0412

Specialty(s) Performing Procedure

86.8% NEPHROLOGY
10.2% INTERNAL MEDICINE
1.0% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
77290		XXX	1.56	ASTRO	Total:	334,547		Yes Aug05
Therapeutic radiology simulation-aided field setting; complex					NF Total	129,327	Top NF RADIATION ONCOLOGY	
					Fac Total	187,175	Top Fac RADIATION ONCOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	70		70												

IWPUT 0.0223

Specialty(s) Performing Procedure

94.6% RADIATION ONCOLOGY
4.1% DIAGNOSTIC RADIOLOGY
0.3% RADIATION THERAPY CENTERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99348		XXX	1.56	AAFP, APMA, AAP	Total:	573,847		Yes Feb07
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.					NF Total	282,898	Top NF PODIATRY	
					Fac Total	5	Top Fac NURSE PRACTITIONERS	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
9	25	10	44												

IWPUT 0.0454

Specialty(s) Performing Procedure

49.3% PODIATRY
16.9% INTERNAL MEDICINE
12.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
46930		090	1.61	ACS, ASCRoS	Total:	23,167		Yes April08
Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)					NF Total	5,026	Top NF GASTROENTEROLOGY	
					Fac Total	2,424	Top Fac GASTROENTEROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
13	5	5	46										1		

IWPUT 0.0474

Specialty(s) Performing Procedure

32.2% GASTROENTEROLOGY
21.1% COLORECTAL SURGERY(FORMERLY PROCTOLOGY)
15.0% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
88321		XXX	1.63	CAP	Total:	188,503		Yes Aug05
Consultation and report on referred slides prepared elsewhere					NF Total	47,313	Top NF CLINICAL LABORATORY (IND.	
					Fac Total	92,321	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	50		50												

IWPUT 0.0326

Specialty(s) Performing Procedure

66.3% PATHOLOGY
25.1% CLINICAL LABORATORY (IND.
7.7% DERMATOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99304		XXX	1.64	AGA	Total:	295,356		Yes Feb07
Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.					NF Total	35,634	Top NF PODIATRY	
					Fac Total	39,684	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	23	10	43												

IWPUT 0.0518

Specialty(s) Performing Procedure

20.6% INTERNAL MEDICINE
18.9% PODIATRY
18.3% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99318		XXX	1.71	AGA	Total:	139,627		Yes Feb07
					NF Total	25,287	Top NF INTERNAL MEDICINE	
					Fac Total	25,845	Top Fac INTERNAL MEDICINE	

Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	27	10	47												

IWPUT 0.0467

Specialty(s) Performing Procedure

36.6% INTERNAL MEDICINE
27.6% FAMILY PRACTICE
19.8% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99335		XXX	1.72	Home Care Medicine and Collaborators	Total:	712,101		Yes Feb07
					NF Total	204,166	Top NF INTERNAL MEDICINE	
					Fac Total	679	Top Fac INTERNAL MEDICINE	

Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
9	25	10	44												

IWPUT 0.0518

Specialty(s) Performing Procedure

28.8% INTERNAL MEDICINE
17.6% FAMILY PRACTICE
17.3% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
55876		000	1.73	AUA, ASTRO, ACR	Total:	19,365		**Yes April10**
Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple					NF Total	12,123	Top NF UROLOGY	
					Fac Total	2,786	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
29	20	10	59												

IWPUT 0.0428

Specialty(s) Performing Procedure

77.0% UROLOGY
17.1% RADIATION ONCOLOGY
3.9% DIAGNOSTIC RADIOLOGY

36514		000	1.74	ASH	Total:	22,830		**Yes Sept02**
Therapeutic apheresis; for plasma pheresis					NF Total	228	Top NF MEDICAL ONCOLOGY	
					Fac Total	9,793	Top Fac PATHOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
40	20	15	75												

IWPUT 0.0254

Specialty(s) Performing Procedure

43.2% PATHOLOGY
35.0% NEPHROLOGY
3.7% HEMATOLOGY/ONCOLOGY

93351		XXX	1.75	ACC	Total:	260,934		**Yes April08**
Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision					NF Total	219,098	Top NF CARDIOLOGY	
					Fac Total	19,857	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	20	10	35												

IWPUT 0.0707

Specialty(s) Performing Procedure

91.6% CARDIOLOGY
6.6% INTERNAL MEDICINE
0.6% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11442		010	1.77	AAD	Total:	47,795		Yes Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm					NF Total	17,018	Top NF DERMATOLOGY	
					Fac Total	3,592	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	25	5	56									1			

IWPUT 0.0382

Specialty(s) Performing Procedure

36.5% DERMATOLOGY
20.1% PLASTIC AND RECONSTUCTIVE SURGERY
13.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
92004		XXX	1.82	AAO, AOA(HCPAC)	Total:	2,123,579		Yes Feb07
Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits					NF Total	1,259,540	Top NF OPHTHALMOLOGY	
					Fac Total	35,191	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	25	10	40												

IWPUT 0.0594

Specialty(s) Performing Procedure

61.0% OPHTHALMOLOGY
38.8% OPTOMETRY
0.0% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11403		010	1.84	AAD, ACS	Total:	52,154		Yes Aug05
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm					NF Total	18,585	Top NF DERMATOLOGY	
					Fac Total	7,598	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
20	30	10	76									1			

IWPUT 0.0253

Specialty(s) Performing Procedure

36.7% DERMATOLOGY
31.0% GENERAL SURGERY
13.3% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64483		000	1.90	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	803,663		**Yes Oct09**
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level					NF Total	116,273	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	119,409	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
24	15	10	49												

IWPUT 0.0816

Specialty(s) Performing Procedure

28.7% INTERVENTIONAL PAIN MANAGEMENT
25.8% PHYSICAL MEDICINE AND REHABILITATION
24.1% ANESTHESIOLOGY

99239		XXX	1.90	ACP, AAFP, AOA, SGIM	Total:	3,444,392		**Yes Feb06**
Hospital discharge day management; more than 30 minutes					NF Total	337	Top NF INTERNAL MEDICINE	
					Fac Total	2,307,131	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	30	15	55												

IWPUT 0.0447

Specialty(s) Performing Procedure

67.0% INTERNAL MEDICINE
12.6% FAMILY PRACTICE
3.6% PSYCHIATRY

99221		XXX	1.92	AAN, AOA, AAFP, ACP, SGIM, SHM	Total:	1,952,569		**Yes Feb06**
Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.					NF Total	46	Top NF CARDIOLOGY	
					Fac Total	293,786	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits			Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	30	10	50												

IWPUT 0.0491

Specialty(s) Performing Procedure

15.0% INTERNAL MEDICINE
11.4% CARDIOLOGY
7.9% GASTROENTEROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
94002		XXX	1.99	AAP, ASA, ACCP/ATS	Total:	17,392		**Yes April06**
Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day					NF Total	31	Top NF PULMONARY DISEASE	
					Fac Total	8,361	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	30	15	60												

IWPUT 0.0439

Specialty(s) Performing Procedure

48.1% ANESTHESIOLOGY
36.7% PULMONARY DISEASE
7.0% INTERNAL MEDICINE

99233		XXX	2.00	IDSA, AAN, AOA, AAFP, ACP, TES, SGIM	Total:	21,650,555		**Yes Feb06**
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.					NF Total	36	Top NF INTERNAL MEDICINE	
					Fac Total	8,549,155	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	30	15	55												

IWPUT 0.0480

Specialty(s) Performing Procedure

39.5% INTERNAL MEDICINE
11.4% PULMONARY DISEASE
9.9% CARDIOLOGY

11601		010	2.07	AAD	Total:	37,103		**Yes Aug05**
Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm					NF Total	21,909	Top NF DERMATOLOGY	
					Fac Total	1,026	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	5	63										1		

IWPUT 0.0326

Specialty(s) Performing Procedure

60.4% DERMATOLOGY
12.9% FAMILY PRACTICE
8.7% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99215		XXX	2.11	ANA, ACRh, AAN, AOA, AAFP, TES, ACP	Total:	9,976,351		Yes Feb06
					NF Total	2,591,568	Top NF INTERNAL MEDICINE	
					Fac Total	205,834	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	35	15	55												

IWPUT 0.0475

Specialty(s) Performing Procedure

28.0% INTERNAL MEDICINE
14.7% FAMILY PRACTICE
11.0% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90937		000	2.11	RPA	Total:	90,344		Yes Oct09
					NF Total	1,062	Top NF NEPHROLOGY	
					Fac Total	72,944	Top Fac NEPHROLOGY	

Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	40	10	60												

IWPUT 0.0415

Specialty(s) Performing Procedure

81.9% NEPHROLOGY
15.8% INTERNAL MEDICINE
0.8% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11641		010	2.17	AAD	Total:	66,697		Yes Aug05
					NF Total	38,542	Top NF DERMATOLOGY	
					Fac Total	3,396	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	5	63										1		

IWPUT 0.0376

Specialty(s) Performing Procedure

58.7% DERMATOLOGY
13.5% PLASTIC AND RECONSTUCTIVE SURGERY
7.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
64614		010	2.20	AANS, AAN, AANEM, AAPMR	Total:	59,575		Yes	April00
Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)					NF Total	22,927	Top NF NEUROLOGY		
					Fac Total	6,644	Top Fac PHYSICAL MEDICINE AND REHABILITA		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	20	15	50												

IWPUT 0.0764

Specialty(s) Performing Procedure

45.7% NEUROLOGY
45.1% PHYSICAL MEDICINE AND REHABILITATION
1.5% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
52000		000	2.23	AUA	Total:	908,545		Yes	Aug05
Cystourethroscopy (separate procedure)					NF Total	707,788	Top NF UROLOGY		
					Fac Total	172,040	Top Fac UROLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
17	15	10	42												

IWPUT 0.1131

Specialty(s) Performing Procedure

96.8% UROLOGY
2.2% OBSTETRICS/GYNECOLOGY
0.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
99292		ZZZ	2.25	ACCP, ATS, SCCM, ASCO, ASA, ASH	Total:	415,547		Yes	Aug05
Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)					NF Total	336	Top NF FAMILY PRACTICE		
					Fac Total	99,493	Top Fac EMERGENCY MEDICINE		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	30		30												

IWPUT 0.0750

Specialty(s) Performing Procedure

24.0% EMERGENCY MEDICINE
21.1% INTERNAL MEDICINE
18.7% PULMONARY DISEASE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
64479		000	2.29	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR	Total:	43,666		**Yes Oct09**
Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level					NF Total	5,564	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	6,283	Top Fac INTERVENTIONAL PAIN MANAGEMENT	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
24	15	10	49												

IWPUT 0.1076

Specialty(s) Performing Procedure

27.1% INTERVENTIONAL PAIN MANAGEMENT
21.8% ANESTHESIOLOGY
17.1% PHYSICAL MEDICINE AND REHABILITATION

31500		000	2.33	ASA, ACEP	Total:	274,961		**Yes April07**
Intubation, endotracheal, emergency procedure					NF Total	82	Top NF PULMONARY DISEASE	
					Fac Total	122,834	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
4	5	10	19												

IWPUT 0.4061

Specialty(s) Performing Procedure

44.7% EMERGENCY MEDICINE
18.1% ANESTHESIOLOGY
12.4% PULMONARY DISEASE

99349		XXX	2.33	AAFP, APMA, AAP	Total:	974,830		**Yes Feb07**
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.					NF Total	306,499	Top NF INTERNAL MEDICINE	
					Fac Total	5	Top Fac FAMILY PRACTICE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	40	15	65												

IWPUT 0.0443

Specialty(s) Performing Procedure

31.4% INTERNAL MEDICINE
24.4% FAMILY PRACTICE
13.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11443		010	2.34	AAO-HNS, ASPS, AAD	Total:	13,828		Yes Aug05
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm					NF Total	4,196	Top NF DERMATOLOGY	
					Fac Total	1,422	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
20	30	10	76									1			

IWPUT 0.0420

Specialty(s) Performing Procedure

31.1% DERMATOLOGY
21.5% PLASTIC AND RECONSTUCTIVE SURGERY
15.4% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99310		XXX	2.35	AGA	Total:	1,122,900		Yes Feb07
Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.					NF Total	119,731	Top NF NURSE PRACTITIONERS	
					Fac Total	217,416	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	35	20	70												

IWPUT 0.0447

Specialty(s) Performing Procedure

29.5% INTERNAL MEDICINE
26.8% NURSE PRACTITIONERS
15.9% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99204		XXX	2.43	APMA, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	8,436,133		Yes Feb06
					NF Total	712,297	Top NF INTERNAL MEDICINE	
					Fac Total	80,861	Top Fac INTERNAL MEDICINE	

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	30	10	45												

IWPUT 0.0698

Specialty(s) Performing Procedure

9.4% INTERNAL MEDICINE
8.8% CARDIOLOGY
8.6% OPHTHALMOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99336		XXX	2.46	Home Care Medicine and Collaborators	Total:	714,841		Yes Feb07
					NF Total	204,886	Top NF INTERNAL MEDICINE	
					Fac Total	610	Top Fac GENERAL SURGERY	

Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	40	15	65												

IWPUT 0.0475

Specialty(s) Performing Procedure

28.7% INTERNAL MEDICINE
25.3% NURSE PRACTITIONERS
20.1% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
95810		XXX	2.50	AAN, AASM, ACNS, ACCP/ATS	Total:	311,700		**Yes April10**
Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist					NF Total	67,902	Top NF PULMONARY DISEASE	
					Fac Total	87,701	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	36.5	15	66												

IWPUT 0.0501

Specialty(s) Performing Procedure

49.9% PULMONARY DISEASE
19.3% NEUROLOGY
10.6% INTERNAL MEDICINE

36556		000	2.50	ACR, ASA, SIR	Total:	516,697		**Yes April03**
Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older					NF Total	447	Top NF NEPHROLOGY	
					Fac Total	160,255	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
25	15	10	50												

IWPUT 0.1192

Specialty(s) Performing Procedure

31.0% ANESTHESIOLOGY
12.9% EMERGENCY MEDICINE
12.2% GENERAL SURGERY

99343		XXX	2.53	AAFP, APMA, AAP	Total:	47,590		**Yes Feb07**
Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.					NF Total	27,426	Top NF PODIATRY	
					Fac Total		Top Fac	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	45	17	77												

IWPUT 0.0403

Specialty(s) Performing Procedure

57.6% PODIATRY
9.7% INTERNAL MEDICINE
9.4% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99284		XXX	2.56	ACEP	Total:	5,555,818		Yes Sept05
					NF Total	1	Top NF	MULTISPECIALTY CLINIC OR GROUP P
					Fac Total	4,212,207	Top Fac	EMERGENCY MEDICINE

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
5	25	10	40												

IWPUT 0.0890

Specialty(s) Performing Procedure

75.8% EMERGENCY MEDICINE
7.1% PHYSICIANS ASSISTANT
6.5% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99222		XXX	2.61	AAN, AOA, AAFP, ACP, SGIM, SHM	Total:	7,451,228		Yes Feb06
					NF Total	113	Top NF	CARDIOLOGY
					Fac Total	1,850,960	Top Fac	INTERNAL MEDICINE

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	40	20	75												

IWPUT 0.0457

Specialty(s) Performing Procedure

24.8% INTERNAL MEDICINE
13.4% CARDIOLOGY
8.7% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11642		010	2.62	AAD, AAO-HNS	Total:	136,818		Yes Aug05
Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm					NF Total	84,081	Top NF DERMATOLOGY	
					Fac Total	10,001	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	25	5	68										1		

IWPUT 0.0481

Specialty(s) Performing Procedure

62.7% DERMATOLOGY
15.7% PLASTIC AND RECONSTUCTIVE SURGERY
6.7% OTOLARYNGOLOGY

99326		XXX	2.63	Home Care Medicine and Collaborators	Total:	37,184		Yes Feb07
Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.					NF Total	9,070	Top NF PODIATRY	
					Fac Total	37	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	45	17	77												

IWPUT 0.0425

Specialty(s) Performing Procedure

24.4% PODIATRY
22.1% INTERNAL MEDICINE
15.8% NURSE PRACTITIONERS

51102		000	2.70	AUA	Total:	13,947		Yes April08
Aspiration of bladder; with insertion of suprapubic catheter					NF Total	1,593	Top NF UROLOGY	
					Fac Total	8,564	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
25	20	15	60												

IWPUT 0.0938

Specialty(s) Performing Procedure

72.8% UROLOGY
10.5% DIAGNOSTIC RADIOLOGY
9.0% OBSTETRICS/GYNECOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11043		000	2.70	APMA, ACS	Total:	192,920		Yes April10
Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less					NF Total	27,806	Top NF PODIATRY	
					Fac Total	37,879	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
41	30	15	86												

IWPUT 0.0506

Specialty(s) Performing Procedure

26.7% GENERAL SURGERY
22.6% PODIATRY
9.4% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
31622		000	2.78	ACCP/ATS	Total:	84,807		Yes April09
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)					NF Total	773	Top NF OTOLARYNGOLOGY	
					Fac Total	43,610	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
20	30	15	65												

IWPUT 0.0689

Specialty(s) Performing Procedure

51.6% PULMONARY DISEASE
15.1% THORACIC SURGERY
7.8% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
12052		010	2.87	ADA, ASPS, AAO-HNS, ACEP	Total:	75,927		Yes Aug05
Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm					NF Total	47,416	Top NF DERMATOLOGY	
					Fac Total	6,179	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
14	30	10	70									1			

IWPUT 0.0641

Specialty(s) Performing Procedure

65.2% DERMATOLOGY
10.2% PLASTIC AND RECONSTUCTIVE SURGERY
8.5% EMERGENCY MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99306		XXX	3.06	AGA	Total:	1,271,496		**Yes Feb07**
Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.					NF Total	175,210	Top NF INTERNAL MEDICINE	
					Fac Total	436,579	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	45	20	80												

IWPUT 0.0506

Specialty(s) Performing Procedure

48.1% INTERNAL MEDICINE
22.3% FAMILY PRACTICE
5.9% GERIATRIC MEDICINE

11623		010	3.11	AAO-HNS, ASPS, AAD	Total:	26,337		**Yes Aug05**	
Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm					NF Total	14,535	Top NF DERMATOLOGY		
					Fac Total	2,088	Top Fac PLASTIC AND RECONSTUCTIVE SURG		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	30	10	93										1		

IWPUT 0.0439

Specialty(s) Performing Procedure

56.9% DERMATOLOGY
14.8% PLASTIC AND RECONSTUCTIVE SURGERY
10.9% GENERAL SURGERY

90962		XXX	3.15	RPA	Total:	187,916		**Yes Feb08**	
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month					NF Total	136,679	Top NF NEPHROLOGY		
					Fac Total	15,613	Top Fac NEPHROLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	63		63												

IWPUT 0.0500

Specialty(s) Performing Procedure

81.0% NEPHROLOGY
13.0% INTERNAL MEDICINE
3.3% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11604		010	3.17	ACS, AAD	Total:	30,427		Yes Aug05
Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm					NF Total	15,694	Top NF DERMATOLOGY	
					Fac Total	3,038	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	40	10	103										1		

IWPUT 0.0344

Specialty(s) Performing Procedure

54.2% DERMATOLOGY
17.5% GENERAL SURGERY
12.9% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99205		XXX	3.17	APMS, ANA, AACE, AOA, AAFP, ACP, SGIM	Total:	3,240,750		Yes Feb06
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.					NF Total	359,477	Top NF NEUROLOGY	
					Fac Total	56,951	Top Fac RADIATION ONCOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
7	45	15	67												

IWPUT 0.0595

Specialty(s) Performing Procedure

12.3% INTERNAL MEDICINE
12.3% NEUROLOGY
10.9% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99350		XXX	3.28	AAFP, AAP	Total:	481,249		Yes Feb07
					NF Total	130,899	Top NF INTERNAL MEDICINE	
					Fac Total	3	Top Fac FAMILY PRACTICE	

Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	75	20	110												

IWPUT 0.0333

Specialty(s) Performing Procedure

27.2% INTERNAL MEDICINE
22.0% NURSE PRACTITIONERS
19.9% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99344		XXX	3.38	AAFP, AAP	Total:	64,616		Yes Feb07
					NF Total	16,499	Top NF INTERNAL MEDICINE	
					Fac Total		Top Fac	

Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	60	25	100												

IWPUT 0.0414

Specialty(s) Performing Procedure

25.5% INTERNAL MEDICINE
24.3% FAMILY PRACTICE
18.5% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11643		010	3.42	AAD, ASPS	Total:	47,757		Yes Aug05
Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm					NF Total	22,169	Top NF DERMATOLOGY	
					Fac Total	5,845	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	30	10	93										1		

IWPUT 0.0542

Specialty(s) Performing Procedure

48.0% DERMATOLOGY
22.1% PLASTIC AND RECONSTUCTIVE SURGERY
11.1% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99327		XXX	3.46	Home Care Medicine and Collaborators	Total:	35,739		Yes Feb07
Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.					NF Total	10,378	Top NF INTERNAL MEDICINE	
					Fac Total	35	Top Fac INTERNAL MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	60	25	100												

IWPUT 0.0427

Specialty(s) Performing Procedure

29.1% INTERNAL MEDICINE
21.2% NURSE PRACTITIONERS
19.9% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99337		XXX	3.58	Home Care Medicine and Collaborators	Total:	182,268		Yes Feb07
					NF Total	53,083	Top NF NURSE PRACTITIONERS	
					Fac Total	63	Top Fac INTERNAL MEDICINE	

Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	60	20	95												

IWPUT 0.0466

Specialty(s) Performing Procedure

29.1% NURSE PRACTITIONERS
25.4% INTERNAL MEDICINE
19.0% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15002		000	3.65	ABA, ACS, ASPS	Total:	17,179		Yes April06
					NF Total	455	Top NF PODIATRY	
					Fac Total	7,458	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

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

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
75	20	20	115												

IWPUT 0.0868

Specialty(s) Performing Procedure

46.0% PLASTIC AND RECONSTUCTIVE SURGERY
25.5% GENERAL SURGERY
8.9% PODIATRY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
31628		000	3.80	ACCP/ATS, ACEP	Total:	39,116		Yes April03
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe					NF Total	180	Top NF PULMONARY DISEASE	
					Fac Total	31,383	Top Fac PULMONARY DISEASE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	40	20	90												

IWPUT 0.0706

Specialty(s) Performing Procedure

80.7% PULMONARY DISEASE
10.4% INTERNAL MEDICINE
5.8% CRITICAL CARE (INTENSIVISTS)

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99285		XXX	3.80	ACEP	Total:	9,188,374		Yes Sept05
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.					NF Total	3	Top NF PHYSICIANS ASSISTANT	
					Fac Total	7,821,602	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
8	40	15	63												

IWPUT 0.0821

Specialty(s) Performing Procedure

85.1% EMERGENCY MEDICINE
4.3% FAMILY PRACTICE
3.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99223		XXX	3.86	AAN, AOA, AAFP, ACP, SGIM, SHM	Total:	11,496,708		Yes Feb06
					NF Total	27	Top NF INTERNAL MEDICINE	
					Fac Total	4,256,172	Top Fac INTERNAL MEDICINE	

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	55	20	90												

IWPUT 0.0559

Specialty(s) Performing Procedure

37.0% INTERNAL MEDICINE
12.8% CARDIOLOGY
6.8% FAMILY PRACTICE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99345		XXX	4.09	AAFP, AAP	Total:	70,094		Yes Feb07
					NF Total	19,964	Top NF INTERNAL MEDICINE	
					Fac Total	1	Top Fac GERIATRIC MEDICINE	

Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	75	30	120												

IWPUT 0.0411

Specialty(s) Performing Procedure

28.5% INTERNAL MEDICINE
20.1% FAMILY PRACTICE
15.0% NURSE PRACTITIONERS

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
11044		000	4.10	APMA, ACS	Total:	53,754		Yes April10
Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less					NF Total	4,931	Top NF PODIATRY	
					Fac Total	12,270	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
51	45	20	116												

IWPUT 0.0605

Specialty(s) Performing Procedure

31.5% GENERAL SURGERY
22.4% PODIATRY
11.7% ORTHOPEDIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
49440		010	4.18	ACR, SIR	Total:	16,533		Yes April07
Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report					NF Total	82	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	10,992	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	38	20	126	1											

IWPUT 0.0529

Specialty(s) Performing Procedure

67.0% DIAGNOSTIC RADIOLOGY
17.1% INTERVENTIONAL RADIOLOGY
9.5% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90966		XXX	4.26	RPA	Total:	222,157		Yes Feb08
End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older					NF Total	180,045	Top NF NEPHROLOGY	
					Fac Total	13,528	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	75		75												

IWPUT 0.0568

Specialty(s) Performing Procedure

87.1% NEPHROLOGY
11.0% INTERNAL MEDICINE
0.7% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90961		XXX	4.26	RPA	Total:	622,643		**Yes Feb08**
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month					NF Total	470,161	Top NF NEPHROLOGY	
					Fac Total	50,109	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	113		113												

IWPUT 0.0377

Specialty(s) Performing Procedure

83.6% NEPHROLOGY
11.7% INTERNAL MEDICINE
2.3% NURSE PRACTITIONERS

62264		010	4.42	ASA, AAPMR and ASIPP	Total:	14,524		**Yes April02**	
Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day					NF Total	2,172	Top NF ANESTHESIOLOGY		
					Fac Total	4,662	Top Fac ANESTHESIOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
40	30	20	109						0.5						

IWPUT 0.0812

Specialty(s) Performing Procedure

47.1% ANESTHESIOLOGY
33.9% INTERVENTIONAL PAIN MANAGEMENT
8.5% PAIN MANAGEMENT

13121		010	4.42	AAO-HNS, ASPS, AAD	Total:	97,197		**Yes Aug05**	
Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm					NF Total	70,188	Top NF DERMATOLOGY		
					Fac Total	5,418	Top Fac DERMATOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
10	60	15	117									2			

IWPUT 0.0483

Specialty(s) Performing Procedure

77.8% DERMATOLOGY
10.3% PLASTIC AND RECONSTUCTIVE SURGERY
2.6% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
99291		XXX	4.50	ACCP, ATS, SCCM, ASCO, ASA, ASH	Total:	4,752,537		Yes Aug05
Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes					NF Total	4,068	Top NF FAMILY PRACTICE	
					Fac Total	1,132,760	Top Fac EMERGENCY MEDICINE	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
15	40	15	70												

IWPUT 0.0957

Specialty(s) Performing Procedure

23.8% EMERGENCY MEDICINE
23.2% PULMONARY DISEASE
22.5% INTERNAL MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15004		000	4.58	ABA, ACS, ASPS	Total:	21,344		Yes April06
Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children					NF Total	3,438	Top NF PODIATRY	
					Fac Total	5,143	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
75	45	30	150												

IWPUT 0.0543

Specialty(s) Performing Procedure

32.3% PODIATRY
30.2% PLASTIC AND RECONSTUCTIVE SURGERY
8.8% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
57267		ZZZ	4.88	ACOG, AUGS	Total:	24,544		Yes April04
Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)					NF Total	147	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	16,878	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	45		45												

IWPUT 0.1084

Specialty(s) Performing Procedure

69.4% OBSTETRICS/GYNECOLOGY
28.1% UROLOGY
1.7% GYNECOLOGY/ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
63661		010	5.08	ISIS, NASS, AANS/CNS, ASA, AAPM	Total:	4,207		**Yes April09**
Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed					NF Total	299	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	914	Top Fac ANESTHESIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	55	20	165						0.5				1		

IWPUT 0.0367

Specialty(s) Performing Procedure

28.5% ANESTHESIOLOGY
27.1% INTERVENTIONAL PAIN MANAGEMENT
14.1% NEUROSURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
90960		XXX	5.18	RPA	Total:	2,094,884		**Yes Feb08**
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month					NF Total	1,654,585	Top NF NEPHROLOGY	
					Fac Total	147,574	Top Fac NEPHROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
	128		128												

IWPUT 0.0405

Specialty(s) Performing Procedure

86.0% NEPHROLOGY
11.8% INTERNAL MEDICINE
1.0% NEUROLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
63685		010	5.19	AAPM, AAPM&R, AANS, AANS, CNS, ASA, ISIS, NASS, AAPM&R, ISIS, NASS	Total:	12,177		**Yes Oct10**
Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling					NF Total	109	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	4,079	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	20	170						0.5				1		

IWPUT 0.0355

Specialty(s) Performing Procedure

33.6% NEUROSURGERY
20.5% INTERVENTIONAL PAIN MANAGEMENT
19.3% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
63688		010	5.30	AAPM, AAPM&R, AANS, AANS, CNS, ASA, ISIS, NASS, AAPM&R, ISIS, NASS	Total:	4,540		**Yes Feb08**
Revision or removal of implanted spinal neurostimulator pulse generator or receiver					NF Total	43	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	1,538	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	55	20	165						0.5				1		

IWPUT 0.0407

Specialty(s) Performing Procedure

34.3% NEUROSURGERY
19.4% INTERVENTIONAL PAIN MANAGEMENT
19.1% ANESTHESIOLOGY

33213		090	5.53	ACC, HRS	Total:	47,249		**Yes Sept11**
Insertion of pacemaker pulse generator only; with existing dual leads					NF Total	145	Top NF CARDIOLOGY	
					Fac Total	38,630	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
22	46	20	130						0.5				1		

IWPUT 0.0666

Specialty(s) Performing Procedure

82.1% CARDIOLOGY
4.6% GENERAL SURGERY
4.1% CARDIAC SURGERY

62362		010	5.60	AAPM, AAPM&R, AANS, CNS, ASA, ISIS, NASS	Total:	6,268		**Yes Oct10**
Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming					NF Total	20	Top NF ANESTHESIOLOGY	
					Fac Total	2,311	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	20	170						0.5				1		

IWPUT 0.0423

Specialty(s) Performing Procedure

37.0% NEUROSURGERY
23.3% INTERVENTIONAL PAIN MANAGEMENT
22.2% ANESTHESIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
26765		090	5.86	ASSH, AAOS	Total:	1,514		**Yes Feb07**
Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each					NF Total	68	Top NF ORTHOPEDIC SURGERY	
					Fac Total	709	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
55	45	20	217						0.5			2	2		

IWPUT 0.0174

Specialty(s) Performing Procedure

51.3% ORTHOPEDIC SURGERY
25.0% PLASTIC AND RECONSTUCTIVE SURGERY
17.0% HAND SURGERY

25071		090	5.91	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	Total:	1,154		**Yes Feb09**
Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater					NF Total	97	Top NF GENERAL SURGERY	
					Fac Total	543	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	15	178						0.5			1	1		

IWPUT 0.0523

Specialty(s) Performing Procedure

55.5% GENERAL SURGERY
15.8% ORTHOPEDIC SURGERY
13.4% PLASTIC AND RECONSTUCTIVE SURGERY

33240		090	6.05	ACC, HRS	Total:	39,134		**Yes Sept11**
Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead					NF Total	55	Top NF CARDIOLOGY	
					Fac Total	35,106	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
33	45	20	140						0.5				1		

IWPUT 0.0771

Specialty(s) Performing Procedure

89.8% CARDIOLOGY
3.8% INTERNAL MEDICINE
3.1% CARDIAC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
62350		010	6.05	AAPM, AAPM&R, AANS, AANS, CNS, ASA, ISIS, NASS, AAPM&R, ISIS, NASS	Total:	6,433		**Yes Oct10**
Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy					NF Total	52	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	1,864	Top Fac NEUROSURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	20	170						0.5				1		

IWPUT 0.0498

Specialty(s) Performing Procedure

29.0% NEUROSURGERY
27.4% ANESTHESIOLOGY
26.7% INTERVENTIONAL PAIN MANAGEMENT

64708		090	6.36	AAOS, ASPS, ASSH, and AOFAS	Total:	3,279		**Yes Oct10**	
Neuroplasty, major peripheral nerve, arm or leg, open; other than specified					NF Total	33	Top NF DIAGNOSTIC RADIOLOGY		
					Fac Total	1,290	Top Fac ORTHOPEDIC SURGERY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
55	60	15	220						0.5			3	1		

IWPUT 0.0314

Specialty(s) Performing Procedure

39.5% ORTHOPEDIC SURGERY
20.9% PLASTIC AND RECONSTUCTIVE SURGERY
13.7% HAND SURGERY

14000		090	6.37	AAD, AAO-HNS, ACS, ASPS	Total:	10,319		**Yes Oct08**	
Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less					NF Total	3,457	Top NF DERMATOLOGY		
					Fac Total	1,834	Top Fac PLASTIC AND RECONSTUCTIVE SURG		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
25	64	22	192										3.5		

IWPUT 0.0300

Specialty(s) Performing Procedure

35.9% DERMATOLOGY
32.9% PLASTIC AND RECONSTUCTIVE SURGERY
20.3% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
25076		090	6.74	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	1,108		Yes Feb09
Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm					NF Total	44	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	485	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	20	206						0.5			1	2		

IWPUT 0.0467

Specialty(s) Performing Procedure

44.8% ORTHOPEDIC SURGERY
18.9% HAND SURGERY
18.1% GENERAL SURGERY

26116		090	6.74	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	4,403		Yes Feb09
Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm					NF Total	78	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	2,338	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	15	201						0.5			1	2		

IWPUT 0.0492

Specialty(s) Performing Procedure

54.3% ORTHOPEDIC SURGERY
31.4% HAND SURGERY
10.9% PLASTIC AND RECONSTUCTIVE SURGERY

15823		090	6.81	AOA	Total:	103,401		Yes April10
Blepharoplasty, upper eyelid; with excessive skin weighting down lid					NF Total	11,911	Top NF OPHTHALMOLOGY	
					Fac Total	79,381	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
16	45	10	161						0.5			3	1		

IWPUT 0.0722

Specialty(s) Performing Procedure

88.3% OPHTHALMOLOGY
9.6% PLASTIC AND RECONSTUCTIVE SURGERY
1.7% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
26615		090	7.07	ASSH, AAOS	Total:	1,640		**Yes Feb07**
Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone					NF Total	18	Top NF ORTHOPEDIC SURGERY	
					Fac Total	992	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
55	45	20	217						0.5			2	2		

IWPUT 0.0443

Specialty(s) Performing Procedure

61.6% ORTHOPEDIC SURGERY
20.5% HAND SURGERY
15.4% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
26113		090	7.13	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	1,028		**Yes Feb09**
Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater					NF Total	20	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	454	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	58	15	214						0.5			1	2		

IWPUT 0.0449

Specialty(s) Performing Procedure

45.4% ORTHOPEDIC SURGERY
30.2% HAND SURGERY
17.6% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
14020		090	7.22	AAD, AAO-HNS, ACS, ASPS	Total:	23,697		**Yes Oct08**
Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less					NF Total	10,165	Top NF DERMATOLOGY	
					Fac Total	4,406	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
29	78	24	223										4		

IWPUT 0.0276

Specialty(s) Performing Procedure

46.9% DERMATOLOGY
34.4% PLASTIC AND RECONSTUCTIVE SURGERY
7.4% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
24076		090	7.41	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	1,124		**Yes Feb09**
Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm					NF Total	52	Top NF GENERAL SURGERY	
					Fac Total	412	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
68	60	20	229						0.5			1	2		

IWPUT 0.0432

Specialty(s) Performing Procedure

37.6% GENERAL SURGERY
36.9% ORTHOPEDIC SURGERY
10.2% PLASTIC AND RECONSTUCTIVE SURGERY

26735		090	7.42	ASSH, AAOS	Total:	1,522		**Yes Feb07**
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each					NF Total	20	Top NF ORTHOPEDIC SURGERY	
					Fac Total	873	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	60	20	237						0.5			2	2		

IWPUT 0.0372

Specialty(s) Performing Procedure

58.7% ORTHOPEDIC SURGERY
21.6% PLASTIC AND RECONSTUCTIVE SURGERY
18.2% HAND SURGERY

25116		090	7.56	AAOS, ASSH	Total:	1,040		**Yes Oct10**
Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum					NF Total	8	Top NF ORTHOPEDIC SURGERY	
					Fac Total	545	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
65	60	20	249						0.5			1	3		

IWPUT 0.0307

Specialty(s) Performing Procedure

53.2% ORTHOPEDIC SURGERY
32.8% HAND SURGERY
11.8% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
21556		090	7.66	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	Total:	3,554		Yes Feb09
Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm					NF Total	131	Top NF GENERAL SURGERY	
					Fac Total	1,377	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
68	60	25	234						0.5			1	2		

IWPUT 0.0455

Specialty(s) Performing Procedure

42.4% GENERAL SURGERY
37.2% OTOLARYNGOLOGY
10.0% PLASTIC AND RECONSTUCTIVE SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
67904		090	7.97	AAO	Total:	45,147		Yes Aug05
Repair of blepharoptosis; (tarso) levator resection or advancement, external approach					NF Total	5,307	Top NF OPHTHALMOLOGY	
					Fac Total	36,384	Top Fac OPHTHALMOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
35	45	15	185						0.5			3	1		

IWPUT 0.0892

Specialty(s) Performing Procedure

92.3% OPHTHALMOLOGY
6.3% PLASTIC AND RECONSTUCTIVE SURGERY
0.9% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33207		090	8.05	ACC	Total:	24,763		Yes April07
Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular					NF Total	38	Top NF CARDIOLOGY	
					Fac Total	19,913	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	60	30	238		1				1				1		

IWPUT 0.0493

Specialty(s) Performing Procedure

80.6% CARDIOLOGY
5.5% GENERAL SURGERY
4.4% THORACIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
22524		010	8.54	AAOS, AANS, ASA, NASS, SIR, ACR, AAPM	Total:	24,197		Yes Oct10
Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar					NF Total	50	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	8,656	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	55	20	177						0.5				1		

IWPUT 0.0973

Specialty(s) Performing Procedure

35.8% ORTHOPEDIC SURGERY
27.2% DIAGNOSTIC RADIOLOGY
23.0% NEUROSURGERY

22521		010	8.65	AANS American College of Radiology American Society of Neuroradiology North American Spine Association Society of Cardiovascular & Interventional Radiology	Total:	12,100		Yes Oct10
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar					NF Total	745	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	6,629	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	75	30	177						0.5				1		

IWPUT 0.0759

Specialty(s) Performing Procedure

60.9% DIAGNOSTIC RADIOLOGY
10.4% INTERVENTIONAL RADIOLOGY
9.6% ORTHOPEDIC SURGERY

14001		090	8.78	AAD, AAO-HNS, ACS, ASPS	Total:	9,240		Yes Oct08
Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm					NF Total	2,962	Top NF DERMATOLOGY	
					Fac Total	1,863	Top Fac GENERAL SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
49	105	26	291						0.5				4		

IWPUT 0.0266

Specialty(s) Performing Procedure

36.6% DERMATOLOGY
30.6% PLASTIC AND RECONSTUCTIVE SURGERY
21.5% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
22523		010	9.04	AAOS, AANS, ASA, NASS, SIR, ACR, AAPM	Total:	21,675		Yes Oct10
Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic					NF Total	37	Top NF INTERVENTIONAL PAIN MANAGEMENT	
					Fac Total	7,895	Top Fac ORTHOPEDIC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	58	20	180						0.5				1		

IWPUT 0.1009

Specialty(s) Performing Procedure

36.5% ORTHOPEDIC SURGERY
26.9% DIAGNOSTIC RADIOLOGY
23.2% NEUROSURGERY

28003		090	9.06	AAOS, APMA	Total:	3,657		Yes Oct10	
Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas					NF Total	599	Top NF PODIATRY		
					Fac Total	2,005	Top Fac PODIATRY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
51	53	20	323	1	1				1			2	3		

IWPUT 0.0072

Specialty(s) Performing Procedure

71.2% PODIATRY
11.6% GENERAL SURGERY
11.5% ORTHOPEDIC SURGERY

50593		010	9.13	SIR, ACR, AUA	Total:	1,352		Yes April07	
Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy					NF Total	9	Top NF DIAGNOSTIC RADIOLOGY		
					Fac Total	872	Top Fac DIAGNOSTIC RADIOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
65	90	20	217						0.5				1		

IWPUT 0.0640

Specialty(s) Performing Procedure

65.2% DIAGNOSTIC RADIOLOGY
21.1% UROLOGY
13.5% INTERVENTIONAL RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
22520		010	9.22	SIR, NASS, ASNR, AAOS, AANS/CNS, ACR	Total:	11,422		Yes Oct10
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic					NF Total	713	Top NF DIAGNOSTIC RADIOLOGY	
					Fac Total	6,520	Top Fac DIAGNOSTIC RADIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	45	30	177						0.5				1		

IWPUT 0.1291

Specialty(s) Performing Procedure

63.3% DIAGNOSTIC RADIOLOGY
10.2% INTERVENTIONAL RADIOLOGY
9.4% ORTHOPEDIC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
14060		090	9.23	AAD, AAO-HNS, ACS, ASPS	Total:	96,958		Yes Oct08
Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less					NF Total	46,804	Top NF DERMATOLOGY	
					Fac Total	13,800	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
30	60	15	183									2	2		

IWPUT 0.0899

Specialty(s) Performing Procedure

55.0% DERMATOLOGY
22.7% PLASTIC AND RECONSTUCTIVE SURGERY
11.3% OTOLARYNGOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15576		090	9.37	AAO_HNS, ACS, ASPS	Total:	3,935		Yes Oct08
Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral					NF Total	930	Top NF DERMATOLOGY	
					Fac Total	1,164	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
70	90	30	271						0.5			1	2		

IWPUT 0.0484

Specialty(s) Performing Procedure

33.7% PLASTIC AND RECONSTUCTIVE SURGERY
30.1% DERMATOLOGY
18.6% OPHTHALMOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
21015		090	9.89	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	Total:	2,322		**Yes Feb09**
Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm					NF Total	262	Top NF DERMATOLOGY	
					Fac Total	853	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
68	75	30	277						0.5			1	3		

IWPUT 0.0527

Specialty(s) Performing Procedure

46.1% PLASTIC AND RECONSTUCTIVE SURGERY
16.8% GENERAL SURGERY
12.2% OTOLARYNGOLOGY

21025		090	10.03	AAOMS, ADA	Total:	1,407		**Yes Feb08**
Excision of bone (eg, for osteomyelitis or bone abscess); mandible					NF Total	406	Top NF ORAL SURGERY	
					Fac Total	228	Top Fac OTOLARYNGOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
85	90	30	283									2	2		

IWPUT 0.0530

Specialty(s) Performing Procedure

41.3% ORAL SURGERY
37.7% MAXILLOFACIAL SURGERY
16.8% OTOLARYNGOLOGY

60220		090	11.19	ACS, AAO-HNS	Total:	8,652		**Yes April08**
Total thyroid lobectomy, unilateral; with or without isthmusectomy					NF Total	17	Top NF OTOLARYNGOLOGY	
					Fac Total	4,254	Top Fac OTOLARYNGOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
72	90	40	267						0.5				2		

IWPUT 0.0710

Specialty(s) Performing Procedure

49.4% OTOLARYNGOLOGY
44.9% GENERAL SURGERY
2.2% SURGICAL ONCOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
58660		090	11.59	ACOG	Total:	1,833		**Yes April97**
Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)					NF Total	13	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	1,346	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
48	90	30	210						0.5				1		

IWPUT 0.0916

Specialty(s) Performing Procedure

74.2% OBSTETRICS/GYNECOLOGY
17.1% GENERAL SURGERY
3.7% GYNECOLOGY/ONCOLOGY

58720		090	12.16	ACOG	Total:	4,584		**Yes Sept05**
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)					NF Total	22	Top NF OBSTETRICS/GYNECOLOGY	
					Fac Total	2,499	Top Fac OBSTETRICS/GYNECOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
52	90	30	309	1	1				1			1	1		

IWPUT 0.0621

Specialty(s) Performing Procedure

55.0% OBSTETRICS/GYNECOLOGY
18.9% GYNECOLOGY/ONCOLOGY
17.7% GENERAL SURGERY

38571		010	14.76	AUA	Total:	7,078		**Yes Aug95**
Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy					NF Total	12	Top NF UROLOGY	
					Fac Total	6,004	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	180		272									2			

IWPUT 0.0692

Specialty(s) Performing Procedure

85.0% UROLOGY
10.4% GYNECOLOGY/ONCOLOGY
3.7% OBSTETRICS/GYNECOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
33249		090	15.17	ACC	Total:	59,749		Yes	May99
Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber					NF Total	102	Top NF CARDIOLOGY		
					Fac Total	54,140	Top Fac CARDIOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	120		249										3		

IWPUT 0.0910

Specialty(s) Performing Procedure

90.8% CARDIOLOGY
4.2% INTERNAL MEDICINE
2.5% CARDIAC SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
58150		090	17.31	ACOG	Total:	13,420		Yes	Sept05
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);					NF Total	63	Top NF OBSTETRICS/GYNECOLOGY		
					Fac Total	9,952	Top Fac OBSTETRICS/GYNECOLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	120	30	394	3	1				1				2		

IWPUT 0.0712

Specialty(s) Performing Procedure

74.6% OBSTETRICS/GYNECOLOGY
19.8% GYNECOLOGY/ONCOLOGY
2.6% GENERAL SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?	
50220		090	18.68	AUA	Total:	1,674		Yes	Aug95
Nephrectomy, including partial ureterectomy, any open approach including rib resection;					NF Total	5	Top NF UROLOGY		
					Fac Total	1,252	Top Fac UROLOGY		

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	120	45	432	5					1				3		

IWPUT 0.0695

Specialty(s) Performing Procedure

75.1% UROLOGY
21.5% GENERAL SURGERY
1.3% VASCULAR SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
15738		090	19.04	ASPS	Total:	5,393		Yes Aug95
Muscle, myocutaneous, or fasciocutaneous flap; lower extremity					NF Total	124	Top NF PLASTIC AND RECONSTUCTIVE SURG	
					Fac Total	3,561	Top Fac PLASTIC AND RECONSTUCTIVE SURG	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	150	30	460	6					1		1	2	1		

IWPUT 0.0605

Specialty(s) Performing Procedure

68.3% PLASTIC AND RECONSTUCTIVE SURGERY
8.9% GENERAL SURGERY
8.3% VASCULAR SURGERY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
37215		090	19.68	AAN, AANS, ACC, ACR ASITN, SCAI, SIR, SVS	Total:	8,795		Yes April04
Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection					NF Total	10	Top NF CARDIOLOGY	
					Fac Total	4,506	Top Fac CARDIOLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
90	103	30	347		1				1				2		

IWPUT 0.1223

Specialty(s) Performing Procedure

51.3% CARDIOLOGY
19.3% VASCULAR SURGERY
8.2% DIAGNOSTIC RADIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
50546		090	21.87	AUA	Total:	1,972		Yes May99
Laparoscopy, surgical; nephrectomy, including partial ureterectomy					NF Total	6	Top NF UROLOGY	
					Fac Total	1,796	Top Fac UROLOGY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
60	205	18	466	3					1				2	1	

IWPUT 0.0641

Specialty(s) Performing Procedure

91.4% UROLOGY
8.0% GENERAL SURGERY
0.1% PEDIATRIC MEDICINE

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33533		090	33.75	STS	Total:	74,561		Yes Aug05
Coronary artery bypass, using arterial graft(s); single arterial graft					NF Total	64	Top NF CARDIAC SURGERY	
					Fac Total	39,150	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	151	40	675	1	1	3	1		1			1		1	

IWPUT 0.1000

Specialty(s) Performing Procedure

52.6% CARDIAC SURGERY
38.7% THORACIC SURGERY
4.2% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33426		090	43.28	STS	Total:	6,246		Yes Aug05
Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring					NF Total	5	Top NF CARDIAC SURGERY	
					Fac Total	3,194	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	205	40	776	1	2	3	1		1				1	1	

IWPUT 0.1110

Specialty(s) Performing Procedure

51.2% CARDIAC SURGERY
40.7% THORACIC SURGERY
3.4% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33512		090	43.98	STS	Total:	2,970		Yes Aug05
Coronary artery bypass, vein only; 3 coronary venous grafts					NF Total	5	Top NF CARDIAC SURGERY	
					Fac Total	1,608	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	213	40	832	1	2	4	1		1			1		1	

IWPUT 0.1030

Specialty(s) Performing Procedure

54.3% CARDIAC SURGERY
37.3% THORACIC SURGERY
3.7% CARDIOLOGY

CPT Code	Description	Global Period	Work RVU	Specialty Society(s) Who Submitted Code	2010 Medicare Utilization Data			Reviewed by RUC?
33863		090	58.79	STS	Total:	1,605		Yes Feb10
Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)					NF Total	0	Top NF CARDIAC SURGERY	
					Fac Total	858	Top Fac CARDIAC SURGERY	

RUC Time Elements

Service Period Time				Hospital Visits				Post Operative Visits			Office Visits				
Pre	Intra	Post	Total	99231	99232	99233	99291	99292	99238	99239	99211	99212	99213	99214	99215
95	287	40	905	1	2	3	2		1					1	

IWPUT 0.1210

Specialty(s) Performing Procedure

53.5% CARDIAC SURGERY
37.6% THORACIC SURGERY
4.3% CARDIOLOGY

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Presacral Lumbar Interbody Fusion

In February 2012, the CPT Editorial Panel created CPT code 22586 *Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1* interspace. The following Level of Interest process did not generate any specialty society willing to develop relative value recommendations for CPT code 22586. **Therefore, the RUC offers no recommendation for CPT code 22586.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
22586	Z1	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace (Do not report 22586 in conjunction with 20930-20938, 22840, 22848, 72275, 77003, 77011, 77012)	090	RUC Recommends "No Recommendation"
▲0195T		Arthrodesis, pre-sacral interbody technique, ~~including~~ disc space preparation, discectomy, without instrumentation, with image guidance ~~ing (when performed)~~, includes bone graft when performed, and discectomy to prepare interspace~~,~~; L5-S1 ~~lumbar; single~~ interspace *(Do not report 0195T, 0196T in conjunction with 22558, 22845, 22851, 76000,* 76001, 77002, 77003, 77011, 77012, *76380, 76496, 76497)*	XXX	Carrier Price

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▲0196T		~~each~~ ~~additional~~ L4-L5 interspace (List separately in addition to code for primary procedure) (Use 0196T in conjunction with ~~225XX1 or~~ 0195T) (Do not report 0195T, 0196T in conjunction with 20930-20938, 22840, 22848, 22558, 22845, 22851, 72275, 76000, 76380, 76496, 76497, 77002, 77003, 77011, 77012)	ZZZ	Carrier Price

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Presacral Lumbar Interbody Fusion(Tab 6)
Staff Note

The Level of Interest process did not generate any specialty willing to develop relative value recommendations for CPT Code 225XX1 *Arthodesis, pre-sacral interbody technique, including disc space preparation, disectomy with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace*. There has, to the best of staff's recollection and record review, one other instance where a specialty was not willing/able to develop a recommendation. In this past situation, the RUC submitted the following recommendation to CMS:

20970 *Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)*
The CPT Editorial Panel at its August 1998 meeting approved CPT code 20979 Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative). Throughout the remaining RUC and CPT cycles for CPT 2000, no specialty society indicated an interest in surveying the new code for work or practice expense values. At its May RUC 1999 meeting, specialty societies did discuss and comment on potential values despite the absence of formal survey data. Many physicians agreed that the work described in CPT code 20979 was very similar to the procedure reported under CPT 20974 Electrical stimulation to aid bone healing; noninvasive (nonoperative) (work RVU= .62). Other RUC members indicated that the code was very similar to CPT 76880 Echography, extremity, non-vascular, B-Scan and/or real time with image documentation (work RVU = .59). The RUC recommends that HCFA consider this information when formulating a final work relative value unit. However, based on the absence of formal survey data, the RUC is unable to make a final recommendation regarding physician work at this time. CMS published a work RVU of 0.62.

The RUC has also periodically recommended that a code be carrier priced when it is an uncommon procedure and difficult to value at that particular point in time. The CPT application estimated that 10,000 of these procedures are performed each year. The applicant is aware that the RUC will not be receiving survey data/recommendation from a specialty society for this issue.

The RUC's Rules and Procedures that are relevant to this issue are included below:

RUC's Rules and Procedures

In the event that the RUC has not accepted Specialty Society recommendation(s) in the timeframe(s) necessary to notify CMS (in order for CMS to comply with the annual cycle to assign relative values to new CPT codes), the RUC, at its option may forward to CMS:

1. all of the records concerning the outstanding recommendation(s) for CMS's independent evaluation and assignment of relative values to new CPT codes, or

2. forward a portion of the records concerning the outstanding recommendation(s) for CMS's independent evaluation and assignment of relative values to new CPT codes, or

3. the RUC may choose by a two thirds majority vote of those present to formulate and include with these materials its own assessment of the appropriate relative value, or

4. the RUC may choose by a two thirds vote of those present to formulate and include with these materials its own assessment of the appropriate range in which the appropriate relative value lies.

Presacral Lumbar Interbody Fusion

Typical Patient (225XX1)

A 40-year old male presents with history of low back pain and radicular leg pain. The patient continues to have limitations to his activities both at home and at work despite adequate physical therapy and other non-operative interventions. Work up shows degenerative disc disease at L5/S1. The patient is a candidate for lumbar fusion and desires to proceed with pre-sacral interbody fusion including discectomy and posterior fixation.

Typical Patient (0195T)

A 40-year-old male presents with a history of low back pain unresponsive to non-operative management for more than 1 year. Work-up and evaluation show a degenerative disc and/or annular tear at L5/S1. The patient continues to have limitations to his activities both at home and at work despite adequate physical therapy and other non-operative interventions. Examination of the patient is consistent with lumbar annular tear with increased pain with forward bending and or lifting. The patient is a candidate for lumbar fusion and desires to proceed with surgery.

Typical Patient (0196T)

A 45-year-old male presents with a history of low back pain unresponsive to non-operative management for more than 1 year. Work-up and evaluation show a degenerative disc and/or annular tear at L4/L5 and L5/S1. The patient continues to have limitations to his activities both at home and at work despite adequate physical therapy and other non-operative interventions. Examination of the patient is consistent with lumbar annular tear with increased pain with forward bending and or lifting. The patient is a candidate for a level 2 lumbar fusion and desires to proceed with surgery. At the completion of the first level, the second level procedure is performed.

Typical Patient (019XXT)

A 45-year-old male presents with a history of low back pain unresponsive to non-operative management for more than 1 year. Work-up and evaluation show a degenerative disc and/or annular tear at L4/L5 and L5/S1. The patient continues to have limitations to his activities both at home and at work despite adequate physical therapy and other non-operative interventions. Examination of the patient is consistent with lumbar annular tear with increased pain with forward bending and or lifting. The patient is a candidate for a level 2 lumbar fusion and desires to proceed with surgery. At the completion of the first level, the second level procedure is performed.

American Medical Association, Current Procedural Terminology (CPT™)

Coding Change Application

Category I CPT Code(s)

Category III CPT Code(s) – Emerging Technology

Criteria for development and evaluation of CPT Category I and Category III Codes

*In developing new and revised **Category I** codes the CPT Advisory Committee and the CPT Editorial Panel require:*

- *that the service/procedure has received approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs;*
- *that the suggested procedure/service is a distinct service performed by many physicians/practitioners across the United States;*
- *that the clinical efficacy of the service/procedure is well established and documented in U.S. peer review literature;*
- *that the suggested service/procedure is neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes; and*
- *that the suggested service/procedure is not requested as a means to report extraordinary circumstances related to the performance of a procedure/service already having a specific CPT code.*

*The following is used as formalized criteria by the CPT Advisory Committee and the CPT Editorial Panel for evaluating Category III code applications and includes identification of the following elements as guidelines for establishment of a **Category III** code:*

- *A protocol of the study or procedures being performed;*
- *Support from the specialties who would use this procedure;*
- *Availability of United States peer-reviewed literature for examination by the Editorial Panel;*
- *Descriptions of current United States trials outlining the efficacy of the procedure.*

This form plays a vital role in maintaining and increasing the efficiency of the CPT process. It can be used to submit a coding change application for any one of the three categories of CPT codes. As you fill out the form please consider which category of code change you are requesting. For more information on the three categories please see the attached instructions.

Please complete this entire form (insert additional lines and pages as needed). Refer to the accompanying instructions if necessary Once the application is completed, submit the application electronically via CD or e-mail to ccpsubmit@ama-assn.org

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Cover Sheet for Coding Change Application

Date:	12/7/11
Change requested by:	
Name:	Ken Reali
Organization:	TranS1 Inc.
Address:	301 Government Center Drive
City, State, ZIP	Wilmington, NC 28403
Telephone:	910-332-1700
Fax:	910-332-1701
E-mail:	kreali@trans1.com

Please attach this cover sheet to your application.

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Formatting Instructions for the Coding Change Application Form.

When entering code information on this application, please use this formatting. You may copy and paste the following symbols:

λ This symbol precedes a new code (example: λ210XX)

σ This symbol precedes a revised code (example: σ43605)

λXXXXX Parent Code (indent 1.0 inch by holding down the "Ctrl" key and pressing "Tab")

λXXXXX Indented Code (indent 1.2 inches by holding down the "Ctrl" key and pressing "Tab" twice)

When entering text on the form, place the content inside the box that follows the question. This field will expand to hold the complete entry.

1. Does the procedure/service involve the use of a drug, vaccine product* or device that requires approval from the Food and Drug Administration (FDA)?

   [X] Yes (go to 2.)

   [ ] No (go to 3.)

   ** Applications requesting establishment of CPT Codes for vaccine products will not be considered until evidence substantiating completion of Phase III Clinical Trials and review of unblinded data is submitted to AMA. However, coding applications may be considered prior to submission of the Biologic License Application (BLA) to the FDA.*

2. If approval is necessary, has FDA approval been received for the device or drugs for the specific use that you are proposing?

   [X] Yes, FDA has approved all necessary aspects of the service.

   [ ] No. Some necessary element of the service has not received FDA approval.

3. Is the procedure/service for which you are applying a code change performed nationally?

   [X] Yes

   [ ] No

4. Is the procedure/service for which you are applying a code change performed by a large number (as a proportion of practitioners within the specialty or subspecialty) of physician or non-physician health professionals?

   [X] Yes

   [ ] No

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5. Has the clinical efficacy of the procedure/service for which you are requesting a code change been established and well documented?

   [X] Yes

   [ ] No

6. Is the procedure/service for which you are requesting a code change used as a performance or quality measure by any national organization? If yes, please state the organization and name of the measure.

   [ ] Yes*

   [X] No

   [ ] Don't Know

   * Enter the following:
   Organization:

   Name of Measure:

7. Indicate the specific reasons why this code change is necessary (rationale). (Avoid non-rationales. Reasons like "no code currently available" or "need new code" do not describe the clinical reason why you are requesting a coding revision.)

I. Introduction

The pre-sacral approach to lumbar interbody fusion is a minimally invasive technique for achieving an interbody fusion that is an alternative to traditional approaches such as ALIF, TLIF, PLIF or direct lateral. The discectomy and fusion portions of the overall procedure are similar to traditional interbody fusion procedures and hardware. The unique feature of this lumbar interbody fusion procedure is the minimally invasive pre-sacral approach to the lower lumbar region of the spine which spares native anatomy (bone, muscle and ligaments) and reduces soft tissue trauma. This difference in approach will be reflected in the conversion to a new Category I code.

When the pre-sacral interbody fusion application was initially reviewed by the CPT editorial panel in October 2011, there was some confusion regarding the Food and Drug Administration (FDA) clearance for the pre-sacral interbody fusion, as well as, the use of the approach and implant in conjunction with other lumbar spine fusion procedures. The purpose for this application is to address and clarify certain issues that were raised at the October 2011 panel meeting. Furthermore this application contains details regarding how study design justifies Level III status based upon objective study attributes.

II. Proper Coding Methodology for Pre-Sacral Interbody Fusion

The pre-sacral approach to lumbar interbody fusion with its associated implant was cleared by the U.S. FDA in 2004 for use with posterior fixation. In fact, posterior or supplemental fixation is required for most lumbar interbody fusions, such as, anterior lumbar interbody fusion (ALIF) or transforaminal interbody fusion (TLIF) access techniques. The attached FDA clearance letters from the TranS1 AxiaLIF device for pre-sacral interbody fusion and the Medtronic Capstone device for either anterior or transforaminal interbody fusions show that both devices require supplemental fixation instrumentation (Attachments 8, 9 and 10). In most

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cases supplemental fixation is considered to be posterior fixation. Rather than bundle the fixation administration with the interbody fusion procedures, the CPT Editorial Panel has traditionally allowed surgeons their choice of fixation based on the clinical requirements of each case. As a result, the spine instrumentation codes are add-on codes, intended to be used with different arthrodesis CPT codes. This coding structure provides flexibility to the physician in selecting the most appropriate instrumentation, while avoiding multiple CPT spine arthrodesis codes that are differentiated only by type of instrumentation. It also allows for the occasional clinical scenario in which the patient has already been treated with posterior fixation.

Based on existing CPT coding methodologies and the existence of other ALIF and TLIF procedures in the CPT code set that make use of the add-on spine instrumentation codes, the pre-sacral interbody fusion should be adopted as a Category I CPT code with the same coding conventions as these other procedures. Presacral interbody fusion is an analog to the aforementioned interbody fusion procedures and therefore, bundling pre-sacral interbody fusion with posterior instrumentation is not consistent with other procedures in the CPT code set. There are good clinical reasons to maintain flexibility in the selection of posterior instrumentation codes and this should be maintained in establishing Category I CPT codes from the existing Category III codes.

Another area of confusion is whether pre-sacral interbody fusion is generally performed adjacent to more extensive lumbar fusions for disease or deformity. Over the past few years some “long construct” fusions for scoliosis, for example, have been performed adjacent to pre-sacral interbody fusion at L5-S1. While pre-sacral interbody fusions have been performed in this fashion, the vast majority are used strictly for degenerative disease solely requiring single level fusion at L5-S1 or two level fusion at L4-S1, and not adjacent to long constructs for deformities such as scoliosis. In fact, the FDA label states that the procedure and implant is indicated for pseudoarthrosis, spinal stenosis, spondylolisthesis or degenerative disc disease. The Gundanna study of 9,152 pre-sacral interbody fusion patients, discussed later, were for either one level or two level pre-sacral fusions, not pre-sacral fusions in conjunction with other lumbar fusions. While, pre-sacral interbody fusion procedures, like ALIF or TLIF procedures, can technically be performed in conjunction with more extensive lumbar fusions, the typical use is as a stand-alone procedure.

III. The Offered Clinical Literature Support Creation of Category I Codes for 0195T and 0196T

In considering the evidence presented, the Panel disagreed about the level of evidence for these studies. However, we believe that close examination of the characateristics of each study reveals that the requisite level of evidence exists to support a Category I code. Further review shows that for each study presented a research protocol with study questions was created, statistical concerns were accounted for and standardized questionnaires administered. The protocol was then applied to the surgical cases meeting the study criteria. These prospective research considerations serve to eliminate selection bias and result in a more robust study. Also, by focusing on objective quantitative data such as the measured extent of fusion and results from repeated administration of patient derived clinical outcome instruments on pain and disability such as the visual analog scale (VAS) and Oswestry Disability Index (ODI), the studies further reduce bias and allow for statistical tests of significance. This degree of methodological rigor meets the criteria for Level III evidence since the data is obtained from well-designed descriptive studies that allow comparisons to baseline as well as other published literature that exists for alternative procedures.

IV. Clinical Basis for Elevating to Category I

It is appropriate to move the existing CPT Category III codes 0195T (Arthrodesis, pre-sacral interbody technique, including instrumentation, imaging (when performed), and discectomy to prepare interspace, lumbar; single interspace) and 0196T (Arthrodesis, pre-sacral interbody technique, including instrumentation, imaging (when performed), and discectomy to prepare interspace, lumbar;each additional interspace (List separately in addition to code for primary procedure)) to Category I CPT codes. New clinical information has become available since assignment of the Category III code supporting the safety and efficacy of the pre-sacral approach to lumbar interbody fusion. Since the Category III code change proposal was submitted by the North American Spine Society in October 2008, there have been 41 additional peer reviewed publications. Widespread adoption of the procedure has been attained as evidenced by the more than 300

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surgeons actively performing the procedure in the United States, and more than 12,000 procedures (10,000 in the US) completed worldwide.

8. If this application requests addition of a **new code**, specify the recommended terminology (code descriptor) for the proposed CPT code. Specify the placement of the proposed code in the current text of CPT (list section, subsection (example: MUSCULOSKELETAL, HEAD, INCISION λ210XX)). Also list synonyms, eponyms or other technical names for the procedure (example: λ8661X Borrelia burgdorferi (Lyme disease) confirmatory test (e.g., Western blot or immunoblot)).

MUSCULOSKELETAL, SPINE, ARTHRODESIS

225X1, Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots, with image guidance, lumbar; single interspace

+225X2, Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots, with image guidance, lumbar; each additional interspace (List separately in addition to code for primary procedure)

(Use 225X2 in conjunction with 225X1)

(For placement of a posterior instrumentation, see 22840-22865 as appropriate)

(Do not report CT or fluoroscopic guidance separately)

9. If this application requests **revision of a code(s)**, specify the recommended terminology (code descriptor) for the proposed revised code. Use the conventional techniques of strike-outs for deletions and underlining for additions/revisions (example: 33420 Valvotomy, mitral valve (~~commissurotomy~~); closed heart). Also, indicate the revision(s) in context with the current code descriptor (list the complete family of codes related to your request). Please refer to code change application instructions.

N/A

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10. If you are recommending a code **deletion**, please provide the recommended cross-reference (i.e., how is the deleted service now to be coded? Example (33100 has been deleted. To report, see 33030, 33031)).

0195T has been deleted. To report, see λ225X1

+0196T has been deleted. To report, see +λ225X2

11. Please indicate which CPT or HCPCS Level II code(s) are currently being used to report this procedure/service.

0195T Arthrodesis, pre-sacral interbody technique, including instrumentation, imaging (when performed), and discectomy to prepare the interspace, lumbar; single interspace

+0196T each additional interspace (List separately in addition to code for primary procedure)

12. Why is (are) the present code(s) (in 12. above) inadequate to describe procedure/service?

The CPT Category III code for pre-sacral lumbar interbody fusion was originally created to provide a means to report a new procedure that involved different work from an open or endoscopically assisted anterior interbody fusion.

It is clear that distinct codes are needed and that it is time to move the existing codes into Category I. Category III codes are temporary codes for emerging technology. Since the Category III code was developed, new peer reviewed scientific articles have emerged which show the pre-sacral technique achieves equivalent fusion rates with a significantly lower complication profile compared to open spinal fusion methods. The most common risks associated with anterior approaches are bowel or abdominal injury, vascular injury, and blood loss. The most significant risk associated with the pre-sacral approach to lumbar interbody fusion is perforation of the bowel (perforation of the peritoneal cavity) which has a documented historical rate of 0.6% (as documented in the Gundanna paper referenced below). Also, utilization has greatly increased with over 12,000 procedures performed to date worldwide (more than 10,000 of these are in the U.S.).

The CPT Category III codes achieved their purpose; identifying pre-sacral lumbar fusion as unique procedures and allowing new procedures to be tracked. A new Category I CPT code will reflect the new access to the anterior spine while still adhering to the same surgical principles of decompression and fusion. The anterior fusion device delivered via a pre-sacral approach is not investigational as it received FDA 510(k) clearance in December 2004. Of the more than 12,000 procedures that have been performed worldwide, the documented serious complication rate is approximately 1%. This rate is lower than the traditional ALIF complication rate which is quoted in the literature. This procedure is both safe and its results are reproducible. Literature suggests this procedure has been successful in achieving a high fusion rate (as reported in the Patil, Tobler and Gerszten studies referenced below). Its potential benefits to the patient because of it less invasive approach include short length of hospital stay (1 day or less), low blood loss (< 50cc per procedure), and decreased post-operative pain score (Oswestry Disability Index and Visual Analog Scores).

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13. Identify the major differences between the proposed code change and other related codes already in CPT (add additional codes as necessary).

Code 1:

22558: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar.

The code for pre-sacral lumbar interbody fusion is similar to this ALIF code in that both represent an anterior retroperitoneal approach to the anterior lumbar spinal column. The major differences in the ALIF code 22558 and the proposed code (225X1) is the access approach and the visualization. The pre-sacral approach for lumbar interbody fusion utilizes instrumentation that creates a pre-sacral access route to the anterior lumbar spine and utilizes fluoroscopic guidance with specific instrumentation to perform a discectomy, insert bone graft and place the spinal fixation device. The pre-sacral approach is also limited to L5-S1 or L4-S1 fusions.

Code 2:

N/A

14. Please provide a list of CPT codes for all procedures/services which are an integral part of the proposed procedure/service. This list should include CPT codes for all procedures/services which, if coded in addition to the code for the procedure/service proposed here, would represent unbundling.

22845: Anterior Instrumentation; 2 to 3 Vertebral Segments
22851: Application of intervertebral biomechanical device(s) to vertebral defect or interspace
63017: Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, forminotomy or diskectomy, (e.g. spinal stenosis), more than 2 vertebral segments; lumbar
63030: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)
63042: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial fecetectomy, forminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar
63047: Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s) (e.g. spinal or recess stenosis), single vertebral segment; lumbar.76000: Fluoroscopy (up to 1 hour physician time)
76380: CT Limited or localized follow-up study
76496: Unlisted fluoroscopic procedure (e.g. diagnostic, interventional)
76497: Unlisted CT procedure, diagnostic or interventional

15. Is the requested service typically reported on the same date as services reported with existing CPT codes? If yes, please explain why multiple codes are typically reported.

[X] No

[ ] Yes (If yes, provide reason here and answer Question #17)

16, Is the requested code expected to be reported with an add-on code?

[X] Yes

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☐ No

17. Do you request that this service be added to Appendix E (i.e., should this application be presented to the RBRVS Update Committee for valuation as modifier 51 exempt)?

☐ Yes

☒ No

18. For each proposed coding change, please provide (attach) a clinical vignette that describes the typical patient who would receive the procedure(s)/service(s) including diagnosis and relevant conditions. Please refer to the sample format and examples of appropriate clinical vignettes included in the code change application instructions. This same vignette is used during the development of work values by the AMA/Specialty Society RVS Update Committee (RUC). It is important that the description of the typical patient make apparent the degree of complexity required to provide the service.

SEE ATTACHMENT 1

19. For each proposed coding change, please provide (attach) a brief description of the procedure(s)/service(s) performed by the physician or non-physician health care professional. Please refer to the sample format and examples of appropriate descriptions of service included in the code change application instructions. This should be a summary description and should **not** contain the detail or pre, intra and post service breakdowns that are required as part of the AMA/Specialty Society RVS Update Committee (RUC). It is important that the description of the service make apparent the degree of complexity required to provide the service.

If the description includes services that are reported separately, please clearly indicate this separate reporting. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

SEE ATTACHMENT 2

20. What diagnosis or conditions is this service/procedure designed to diagnose/treat?

738.4 Acquired spondylolisthesis

733.82 Nonunion of fracture, V45.4 Arthrodesis status

722.52 Degeneration of lumbar or lumbosacral intervertebral disc

722.73 Intervertebral disc disorder with myelopathy, lumbar region

The pre-sacral approach to lumbar interbody fusion is intended to provide anterior stabilization of the L5-S1 or L4-S1 spinal segment(s) as an adjunct to spinal fusion. This procedure is indicated for patients requiring fusion to treat pseudoarthrosis (unsuccessful previous fusion) spinal stenosis, spondylolisthesis (Grade 1 or 2 for one-level, Grade 1 for two-level), or degenerative disc disease as defined as back pain of discogenic origin with degeneration of the disc confirmed by history and radiographic studies.

The pre-sacral approach to lumbar interbody fusion is intended for minimally invasive access to the anterior portion of the lower lumbar spine for assisting in the treatment of degeneration conditions of the lumbar disc, performing lumbar discectomy, or for assistance in the performance of L5-S1 or L4-S1 interbody fusion.

21. For the proposed coding change, is conscious sedation inherent to this procedure?

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☐ Yes

☒ No

22. What is the incidence of the disease(s) that this procedure is designed to diagnose/treat? Please quantify when possible (e.g. patients per year; admissions per year).

It is estimated that in 2011 there will be approximately 200,000 patients treated surgically for conditions for which pre-sacral lumbar interbody fusion is indicated.

23. How long (i.e. number of years) has this procedure/service been provided for patients? (Medical literature that indicates utilization of this procedure/service should be cited, and a hard copy of the literature should be provided.)

The subject device was first used clinically in June 2003, in Sao Paulo, Brazil where the initial clinical work was performed. In January 2005, the device was first used clinically in the United States. The device was also first used in the European Union during 2005.
See #34 bibliography for publications illustrating use of the procedure.

24. Do many physicians or non-physician health care professionals perform this service across the United States?

☒ Yes

☐ No

25. How often do physicians or non-physician health care professionals perform this service?

☒ Commonly

☐ Sometimes

☐ Rarely

26. How often is this service provided nationally in a one-year period (i.e. what is the yearly frequency)?

Approximately 2000 cases per year

27. Please identify the specialties or subspecialties that might perform this procedure/service.

Orthopedic spine surgery and Neurosurgery

28. Did you contact any of the national offices for the specialty groups listed in the CPT Advisory Committee listing in the CPT codebook? If yes, which one(s)?

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Yes

NASS
AAOS
AANS/CNS
ISASS
SMISS

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29. What is the typical site of service that this procedure is performed in? (please check all that apply)

- [ ] Office or other outpatient setting
- [ ] Emergency department
- [ ] Independent laboratory
- [ ] Domiciliary/rest home
- [X] Hospital inpatient
- [ ] Patient's home
- [ ] Psychiatric facility
- [ ] Nursing facility
- [ ] Hospital outpatient
- [ ] Ambulatory surgical center
- [ ] Other (please specify)

30. If you are recommending a new code, please estimate the percentage of services performed using current codes that would now be coded using the proposed new code. Please cite your data sources (example: Current code 12345 will now be reported by λ123X1 30% of the time, λ123X2 70% of the time).

Code 0195T will now be reported by the new code (λ225X1) 100% of the time.
Codes +1096T will now be reported by the new code (+λ225X2) 100% of the time.

31. Are you aware of any practice parameters/guidelines or policy statements about this particular procedure? If yes, please identify and provide below.

- [ ] Yes
- [X] No
- [ ] Don't Know

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32a Please provide electronic (PDF or Word documents) copy(s) (and internet addresses, if available) of literature to support your application, and cite the author, title, journal, year, volume and page(s) in the "Publication Details and Attributes Grid" (PDA grid) that follows. Each item of submitted literature shall be identified in the PDA grid according to each of the 4 following requirements:

1. Identify the Level of Evidence by selecting a level from the LOE table below;

2. Identify whether this is a U.S. based journal or a non-U.S. based journal, and identify whether the population studied is U.S. or non-U.S. or both;

3. Identify the number of patients studies (total of all group(s) including controls) and indicate whether study is a prospective study;

4. Provide a concise "relevance statement".

General Guidelines for inclusion of the articles are noted in the following:

1. Abstracts are allowed to supplement application but will not be accepted in substitution of full length journal articles.

2. Foreign journals will be permitted if published in the English language.

3. List up to 5 references, of which at least 3 report the procedure/service in a U.S. patient population. Of these, at least 2 articles must report different patient populations or have different authors (no overlapping patient populations or no overlapping authors).

4. At least 1 of the publications meets or exceeds the criteria for evidence level III (i.e. obtained from well-designed, non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies). However, Code Change Applications requesting editorial changes to existing Category I codes and applications for bundled codes to describe unchanged existing Category I services (when provided together) need not meet this requirement.

32b For Category III codes, please reference studies or research performed by national organizations if available.

The following is used as formalized criteria by the CPT Advisory Committee and the CPT Editorial Panel for evaluating Category III code applications, and includes identification of the following elements as guidelines for establishment of a Category III code:

- A protocol of the study or procedures being performed;

- Support from the specialty societies who would use this procedure;

- Availability of U.S. peer-reviewed literature for examination by the CPT Editorial Panel;

- Descriptions of current U.S. trials outlining the efficacy of the procedure.

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Level of Evidence Table - LOE

Level	Type of evidence (based on AHCPR 1992)
Ia	Evidence obtained from meta-analysis of randomized controlled trials
Ib	Evidence obtained from at least one randomized controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomization
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities
V	Evidence obtained from case reports or case series

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Publication Details and Attributes (PDA) Grid					
References	**Level of Evidence Based on LOE Table**	**US or Foreign Peer Reviewed**	**US or Foreign Population Studied**	**Prospective Study**	**Total Patients Studied**
Article #1 *(Author, Title, Journal, Year, Volume and Pages)* Gundanna M, Miller L, Block J: Complications with Axial Presacral Lumbar Interbody Fusion: A Five-Year Postmarket Surveillance Experience. SAS Journal. 2011; Volume 5, pp. 90-94.	*Insert level #* *III*	☒ **U.S.** ☐ **Foreign**	☒ **U.S.** ☐ **Foreign** ☐ **Both**	☐ **Yes** ☒ **No**	*Insert #* *9,152*
Brief description: The Gundanna M, et al study used prospective research techniques to study a database of 9,152 pre-sacral lumbar interbody fusion patients. The pre-defined database was developed to record complaints and complications related to the pre-sacral interbody fusion device or procedure. Complication data were recorded through prospectively established complaint reporting as part of ongoing post-market surveillance. Procedures and training were developed to ensure accurate reporting. Complications were reported in 120 (1.3%) of 9,152 patients, and included bowel injury (n=59, 0.6%), superficial wound and systemic infections (n=9, 0.1%), transient intraoperative hypotension (n=20, 0.2%), migration (n=5, 0.1%), subsidence (n=4, <0.1%), pre-sacral hematoma (n=9, 0.1%), sacral fracture (n=7, 0.1%), vascular injury (n=6, 0.1%), nerve injury (n=3, <0.1%), and ureter injury (n=1, <0.1%). Complications were reported using counts and frequencies with 95% confidence intervals that allowed comparison to historical control groups. χ^2 with Yates' correction for continuity was used to compare complication incidences between single-level and two-level procedures. Patient follow up time points ranged from 3 months to 5 years 3 months. This study represents level III evidence as it is a well characterized prospectively derived study where comparisons to historical controls were performed in terms of complications and adverse events. These elements make this study both descriptive and comparative. **SEE ATTACHMENT 3**					
Article #2 *(Author, Title, Journal, Year, Volume and Pages)* Tobler WD, Ferrara L, The presacral retroperitoneal approach for axial lumbar interbody fusion: A prospective study of clinical outcomes, complications and fusion rates at a follow-up of two years in 26 patients, The Journal of Bone and Joint Surgery, 2011, Vol 93-B, No.7, 955-960.	*Insert level #* *III*	☒ **U.S.** ☐ **Foreign**	☒ **U.S.** ☐ **Foreign** ☐ **Both**	☒ **Yes** ☐ **No**	*Insert #* *26* *Prospective*
Brief description: The Tobler, W.D and Ferrara, L.A. paper was a prospective study of outcomes, complications and fusion rate on 26 patients with symptomatic degenerative disc disease, with follow-up of 2 years. The study used the VAS and ODI questionnaires that were administered pre-operatively, at discharge, and at three weeks and three, six, 12, and 24 months. The evaluation of fusion was by thin-cut CT scans at six and 12 months, and flexion-extension plain radiographs at six, 12 and 24 months. The extent of fusion was determined by an independent radiologist based on FDA established guidance principles allowing comparison with historical control groups. Baseline clinical values were compared with values at two years using a two-sided *t*-test. The resulting p-value of < 0.05 was considered to be statistically significant. "Significant reductions in pain and disability occurred as early as three weeks post-operatively and were maintained. Fusion was achieved in 22 of 24 patients (92%) at 12 months and in 23 patients (96%) at 24 months. One patient (4%) with a pseudoarthrosis underwent successful revision by augmentation of the posterolateral fusion mass through a standard open midline approach." There were no serious adverse events. This study represents level III evidence as the data was collected through a well-defined, prospectively planned trial and allows comparisons to both baseline and historical controls based on the prospectively defined inclusion/exclusion criteria and the ability to view the data across historical controls. **SEE ATTACHMENT 4**					
Article #3 *(Author, Title, Journal, Year, Volume and Pages)* Patil S, Clinical and Radiological Outcomes of Axial Lumbar Interbody Fusion, Orthopedics, 2010, 33(12), 883.	*Insert level #* *III*	☒ **U.S.** ☐ **Foreign**	☒ **U.S.** ☐ **Foreign** ☐ **Both**	☐ **Yes** ☒ **No**	*Insert #* *50*
Brief description:					

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The Patil, et al study, which included 50 patients, enrolled subjects with degenerative conditions of the spine including spondylolisthesis and degenerative disc disease. The study used standing neutral lateral radiographs of the lumbosacral spine obtained preoperatively, six weeks postoperatively, and at the last postoperative visit (six-24 months postoperatively) to analyze the extent of fusion. Two radiographic characteristics were measured: disk space height and Cobb angle. Disk space height was measured as the distance between the anterior superior endplate and inferior endplate. Lumbar lordosis angle, or Cobb angle, was measured as the angle derived from the slope between the upper and lower vertebral endplates. Fusion was also assessed on plain lateral radiographs and computed tomography (CT). Fusion was evaluated using Brantigan and Steffee's criteria, which is defined as a bony continuity between the upper and lower endplates and a lack of radiolucent lines around the screws. All measurements were performed by a single observer. Data were statistically analyzed with paired two-tailed *t* tests allowing scientific comparison to baseline. Patient clinical outcomes were derived from well accepted VAS and ODI questionnaires that were administered to patients during the preoperative evaluation and at three, six, 12 and 24 months post-surgical follow-up visits. ODI scores were reduced from 46 to 22, and VAS scores were lowered from 8.1 to 3.6. Of the 49 patients with postoperative radiographs, 47 (96%) went on to solid fusion. Several patients experienced complications (11/50), including 1 high rectal injury attributed to altered intra-abdominal anatomy , with the most common being superficial infection and pseudoarthrosis. This study represents level III evidence because it is a study with descriptive well characterized data that allows comparisons to the baseline condition of the patients as well as cross comparisons to published historical controls.

SEE ATTACHMENT 5

Article #4 Gerszten PC, Tobler W, Raley TJ, Miller LE, Block JE, Nasca RJ. Axial Presacral Lumbar Interbody Fusion and Percutaneous Posterior Fixation for Stabilization of Lumbosacral Isthmic Spondylolisthesis. Journal of Spinal Disorders & Techniques. Accepted, not yet published. Epub ahead of print September 29, 2011.	*Insert level #* *III*	☒ **U.S.** ☐ **Foreign**	☒ **U.S.** ☐ **Foreign** ☐ **Both**	☐ **Yes** ☒ **No**	*Insert #* *26*

Brief description:

The Gerszten et al paper is a descriptive, comparative, prospectively designed, multi-center study of 26 consecutive patients diagnosed with isthmic spondylolisthesis treated with pre-sacral interbody fusion and posterior fixation. Outcomes for fusion were CT scans and flexion/extension films at 2 years which were compared to historical controls. Data was analyzed using Predictive Analytics Software. Spondylolisthesis slip grade was determined using the Wilcoxson signed-ranked test. Change in pain scores before and after surgery was assessed with paired t-tests allowing comparison to baseline. The Mann-Whitney U test was used to determine the relationship of spondylolisthesis reduction magnitude with baseline patient characteristics and patient outcomes. Patients treated had a 66% reduction in baseline pain scores with a 95% confidence interval (54-78%), and all showed solid fusion at 2-year follow-up. This study represents a singularly defined clinical indication with highly descriptive data that allows comparisons to both baseline patient conditions and historical controls that are also defined as treatments for isthmic spondylolisthesis. These elements make this a level III comparative study.

SEE ATTCHMENT 6

Article #5 *(Author, Title, Journal, Year, Volume and Pages)* Tobler W, Gerszten P, Bradley W, Raley T, Nasca R, Block J: Minimally-invasive Axial Pre-sacral L5-S1 Interbody Fusion: Two Year Clinical and Radiographic Outcomes. Spine. 2011 Sept; Volume 36, Number 20, pp. E1296-E1301.	*Insert level #* *IV*	☒ **U.S.** ☐ **Foreign**	☒ **U.S.** ☐ **Foreign** ☐ **Both**	☐ **Yes** ☒ **No**	*Insert #* *156*

Brief description:

The Tobler WD, et al study retrospectively examined 156 patients from four clinical sites. Inclusion criteria required patients to have received L5-S1 presacral fusion and to have both presurgical and 2 year radiographic or patient-reported clinical follow-up. Subjects meeting inclusion criteria had refractory axial low back pain and degenerative spine conditions with at least 6 months of failed nonoperative management. Evaluation of back pain severity and condition-specific functional impairment was performed pre-operativeley as well as at 2 years follow-up using ODI questionnaires. Developing fusion mass was evaluated using standard anteroposterior and lateral radiographs as well as dynamic flexion-extension films (n=89) and thin cut multiplanar computed tomography scans (n=66). The degree of clinical improvement in pain and functional outcomes over baseline was determined by comparing baseline values for all outcomes with values at 2 years using a two-sided *t* test for statistical significance, and clinical success was defined as change relative to baseline values of at least 30%. Subgroup evaluations of potential predictors of fusion success were analyzed using Fisher's exact test (two tailed). In this study, patients realized 86% and 74% clinically significant improvements in pain and function, respectively, at 2 years post-op. There was a reported 94% fusion rate and no radiographic evidence of device subsidence or joint space narrowing. This study represents level IV evidence.

SEE ATTACHMENT 7

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33. Have you found any publications in addition to those cited in the CCP which offer conflicting data or different opinions
and that you feel are important for Editorial Panel consideration in evaluating this CCP? If so, please provide the
literature reference, level of evidence, the reason that you consider the publication(s) relevant, and why you excluded
them from the articles cited in 32a.

Reference	**Level of Evidence based on LOE Table**	**Brief description regarding relevance and why you excluded from articles in 32a.**
Article #1	*Level #*	*Describe:*
Article #2 *(List Author, Title, Journal, Year, Volume, Pages)*	*Level #*	*Describe:*
Article #3 *(List Author, Title, Journal, Year, Volume, Pages)*	*Level #*	*Describe:*
Article #4 *(List Author, Title, Journal, Year, Volume, Pages)*	*Level #*	*Describe:*

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34. Other Comments

Literature illustrating use of the device is cited below.

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6. Aryan H, Newman C, Acosta F, Coover C, Ames C: Percutaneous Axial Lumbar Interbody Fusion (AxiaLIF) of the L5-S1 Segment: Initial Clinical and Radiographic Experience. Minimally Invasive Neurosurgery. 2008; 51(4): 225-30.

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Every code change applicant shall disclose his or her financial and other potential interest as described below in the course of submitting the code change application.

Interests required to be disclosed:

Applicant may benefit financially from the code change application; and/or

Applicant is a consultant, agent or employee, and applicant should reasonably be aware that applicant's client or employer may benefit financially from the code change proposal.

This does not include any interest that is limited to providing clinical services to patients (including the service(s) for which a code change application is being submitted).

This disclosure does not restrict or limit the ability of the code change applicant to submit the proposal or to advocate for the CPT changes before the Panel or in writing.

Please complete and sign the following Statement of Compliance. The Statement of Compliance will be disclosed to all individuals reviewing/considering the code change application.

Statement on Lobbying

Applicants and other interested parties must not engage in "lobbying" for or against code change applications. "Lobbying" means **unsolicited** communications of any kind made at any time (including during Editorial Panel meetings) for the purpose of attempting to influence either (1) the CPT Advisors' evaluation of or comments upon a code change application or (2) voting by members of the Editorial Panel on a code change application. **Lobbying is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being barred from further participation in the CPT process.** Information that accompanies a code change application, presentations or commentary to the full Editorial Panel during an open meeting and responses to inquiries from a Panel member or a CPT staff member do not constitute "lobbying."

In order for the CPT Editorial Panel to effectively review and act on proposed changes to the CPT code set, code change applications must be reviewed by the CPT Advisors and the Editorial Panel based on the information contained in the application and available clinical literature. CPT staff is responsible for organizing and submitting information to the CPT Advisors and the Editorial Panel for consideration. Information relating to a code change application must be submitted to CPT staff no later than thirty days prior to the start of the Editorial Panel meeting at which the code change application will be considered. In some cases, the Chair of the Editorial Panel may establish rules which allow for supplemental submissions of information to workgroups or facilitation sessions established by the Chair or for postponed or appealed agenda items. (A facilitation session is an informal meeting requested by the Chair during a CPT Editorial Panel meeting to allow interested parties to confer and attempt to reach a consensus recommendation for presentation at the meeting.)

During development of a code change application, an applicant may seek input or assistance from staff or advisors of medical specialty societies but may not engage in "lobbying" as defined above. Medical specialty societies may have their own policies governing interactions with applicants or other interested parties regarding code change applications. The AMA encourages medical societies to work with applicants, from both industry and other medical specialty societies, to assure that code change applications are complete, coherent and consistent with current medical practice. Contacts with consulting medical societies should be limited to that which is necessary to construct and submit the code change application. After the date a code change application is posted for review and comment by the CPT Advisors and the Editorial Panel, contact between an applicant and medical society representatives should be confined to communications pertaining to feedback from the CPT staff or Advisors' comments regarding the application. If an applicant or other interested party wishes

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the CPT Advisors or the Editorial Panel to consider additional information, that information must be submitted to AMA's CPT staff and not directly to the CPT Advisors or the Editorial Panel.

Applicants and other interested parties are invited to participate in open CPT Editorial Panel meetings and present their views on code change applications when recognized by the Chair during the course of the meeting. The views of applicants and other interested parties may be sought during work group or facilitation sessions established by the Chair and participation in a workgroup or a facilitation session is not considered lobbying.

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I understand that I am expected to comply with the CPT Code Change Proposal Conflict of Interest Policy. I will disclose any financial interests or other interest as described in the Conflict of Interest Policy in the above CPT Code Change Proposal. I understand that, should I choose to present the above CPT Code Change Proposal to the CPT Editorial Panel, I have a continuing responsibility to comply with the Conflict of Interest Policy, and I will promptly disclose my interests required to be disclosed under the Policy.

Please check as appropriate:

☐ I have no conflicts as described in the CPT Code Change Proposal Conflict of Interest Policy.

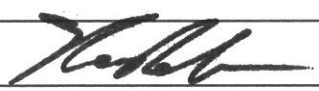
☒ I may benefit financially from the code change proposal; and/or

If checked, please describe:

There is potential that a Category I code change could result in increased company revenue. As President and CEO of the company, there is a potential indirect financial benefit due to the compensation package which is linked to company revenue.

☐ I am a consultant, agent or employee, and my client or employer may benefit financially from the code change proposal.

If checked, please describe:

Signature:  Date: 12/07/2011

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In consideration of the American Medical Association's review of your proposed coding change(s) to CPT, you and the requesting organization, assign to the AMA all rights including copyright, if any, in your proposed changes to CPT. The signature below acknowledges that you have authority to sign this form; and, to the best of your knowledge, the information provided accurately depicts current clinical/surgical practice.

Signature:	
Print Name:	Ken Reali, President and CEO
Organization (if applicable):	TranS1, Inc.
Date:	12/07/2011

Submit your application to:

American Medical Association
Department of CPT Editorial Research and Development
515 N State St
Chicago, Illinois 60654

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If you have any questions concerning the above requirements, please consult with AMA staff prior to the submission of your proposal.

An incomplete application may delay processing of your request and may be returned.

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AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Shoulder Arthroplasty and Implant Removal

In October 2011, the CPT Editorial Panel created two new CPT codes for total shoulder revision, CPT code 23473*Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component* and CPT code 23474 *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component.* The new codes were created because of a CCI edit stating that providers can no longer report an implant removal with a total shoulder revision, as it was previously reported. The specialty society surveyed for the January 2012 RUC meeting, but was not able to collect a sufficient number of surveys for an accurate review and valuation. In January 2012 the RUC approved the specialty society's request to continue collecting survey responses. CMS requested surveys for all base and family codes. CPT code 23331 *Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)* (work RVU=7.63), CPT code 23332 *Removal of foreign body, shoulder; complicated (eg, total shoulder)* (work RVU=12.37) and CPT code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)* (work RVU=22.65) were added and surveys were conducted for the April 2012 RUC meeting. These codes are low volume and as a result have low survey response, however the RUC agreed that enough additional surveys have been collected for the specialty society to provide accurate work RVU recommendations.

23331

The RUC reviewed the code and determined that the CPT descriptor does not accurately depict the "removal of previously-placed implant" and requested that the removal portion of the service be returned to CPT for development of new "implant removal" codes to correlate with the revision shoulder arthroplasty codes. Specifically the codes should distinguish between removal of a prosthesis and a foreign body. **The RUC recommends that CPT code 23331 be referred to CPT for further clarification and that the current work RVU of 7.63 be maintained until the code is revised and resurveyed.**

23332

The RUC reviewed the code and determined that the CPT descriptor does not accurately depict the "removal of previously-placed implant" and requested that the removal portion of the service be returned to CPT for development of new "implant removal" codes to correlate with the revision shoulder arthroplasty codes. Specifically the codes should distinguish between removal of a prosthesis and a foreign body. **The RUC recommends that CPT code 23332 be referred to CPT for further clarification and that the current work RVU of 12.37 be maintained until the code is revised and resurveyed.**

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23472
The RUC reviewed the survey and recommends a work RVU of 22.13, the survey's 25th percentile, a decrease from the current work RVU of 22.65. The specialty society pointed out that the intra-service time in the RUC database is listed as 165, however when the code was surveyed in 2000 the survey indicated that the intra-service time was 155. The current survey indicates that there is now 140 minutes of intra-service time to perform this service. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time is warranted in order to position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. The RUC compared 23472 to the key reference service 23616 *Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement* (work RVU=18.37) and determined that the service requires more physician time and justifies a higher value. The RUC also compared 23472 to 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU=22.65) a comparable procedure in the elbow that was approved at this meeting at a work RVU of 22.00. This service has slightly more positioning work than the elbow which justifies the slightly higher value. **The RUC recommends a work RVU of 22.13 for CPT code 23472.**

23473
The RUC reviewed the survey and recommends a work RVU of 25.00, the survey's 25th percentile. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time is warranted in order to position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. The RUC compared 23473to the key reference service 23210 *Radical resection of tumor; scapula* (work RVU=27.21, intra-service time=210) and determined that this service requires less physician time at 180 minutes intra-service time. Due to less time and in order to maintain rank order the RUC recommends a lower value than the key reference service. The RUC also agreed that the recommended work RVU maintains relativity within the family, specifically compared to 23472 which has less intra-service time. **The RUC recommends a work RVU of 25.00 for CPT code 23473.**

23474
The RUC reviewed the survey and recommends a work RVU of 27.21, below the survey's 25th percentile. The RUC agreed that a value any higher would cause a rank order anomaly in the code family and render intensity that is too high for this procedure. The work RVU recommendation for 23474 was determined based on a direct crosswalk to CPT code 23210 *Radical resection of tumor; scapula* (work RVU=27.21). These codes have intra-service times of 210 and 205 minutes, respectively and the remainder of the post-operative work is the same. The RUC also compared 23474 to 27487 *Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component* (work RVU=27.11) and determined that the codes are consistent with a total time of 513 and 520, respectively. **The RUC recommends a work RVU of 27.21 for CPT code 23474, a direct crosswalk to CPT code 23210.**

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

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
23331	E1	Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)	090	7.63 (No Change) Refer to CPT Editorial Panel
23332	E2	complicated (eg, total shoulder) (Do not report 23331, 23332 in conjunction with 23473, 23474 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder)	090	12.37 (No Change) Refer to CPT Editorial Panel
23472	E3	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (For removal of total shoulder implants, see 23331, 23332) (For osteotomy, proximal humerus, use 24400)	090	22.13
●23473	E4	Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component	090	25.00
●23474	E5	humeral and glenoid component (Do not report 23473, 23474 in conjunction with 23331, 23332 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder)	090	27.21

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23472 Tracking Number E3 Original Specialty Recommended RVU: **22.13**
Presented Recommended RVU: **22.13**
Global Period: 090 RUC Recommended RVU: **22.13**

CPT Descriptor: Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old with incapacitating arthritis undergoes a total shoulder replacement involving both humeral and glenoid components

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning - position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a deltopectoral incision is made from the mid clavicle to the junction to the mid-third of the humerus. The deltopectoral interval is opened allowing identification of the conjoined tendon. Careful protection around neurovascular structures during the case including the axillary and musculocutaneous nerve is imperative. The subscapularis tendon is divided , tagged and mobilized. The anterior capsule is excised. A wide capsular release is performed for exposure and mobilization of the proximal humerus. Dislocation of the shoulder is performed with intraoperative inspection and assessment of the humeral head and glenoid fossa. Precise resection of the proximal humeral head is done utilizing an alignment jig. The humeral canal is reamed and broached to accept the prosthesis. The glenoid fossa is carefully prepared to accept the properly aligned glenoid component in the correct version. This component is fixed in place with cement or screws. Scrupulous preparation and cleansing of the humeral canal is necessary prior to placement of the prosthetic humeral component. Cementing or press-fit of the humeral component within the humeral shaft is performed. Carefully align the humeral component in the proper degree of retroversion to prevent postoperative subluxation or dislocation. The rotator cuff and anterior capsule are repaired. Frequently a subacromial decompression and

acromioplasty with resection of the coracoacromial ligament is done. Reattachment of the subscapularis tendon is accomplished followed by re-approximation of the deltopectoral interval and closure of the subcutaneous tissue and skin.

Description of Post-Service Work: Hospital - through discharge from recovery room: Apply sterile dressings. The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity to ensure that no brachial plexus injury has occurred during surgery. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise, indicating avoidance of passive stretching of the shoulder. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic shoulder. Write orders for progression to active exercise depending on the quality of the rotator cuff tissues and the adequacy of the rotator cuff repair. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	William Creevy, MD; John Heiner, MD; Daniel Nagle, MD; Anne Miller, MD		
Specialty(s):	orthopaedic surgery, hand surgery		
CPT Code:	23472		
Sample Size: 400	**Resp N:** 28	**Response:** 7.0 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	19.00	**43.00**	80.00	200.00
Survey RVW:	18.00	22.13	**25.00**	30.13	50.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**18.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	120.00	120.00	**140.00**	150.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23472	**Recommended Physician Work RVU: 22.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**140.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23616	090	18.37	**RUC Time**

CPT Descriptor Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45400	090	19.44	**RUC Time**	253

CPT Descriptor 1 Laparoscopy, surgical; proctopexy (for prolapse)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.79	**RUC Time**	12,731

CPT Descriptor 2 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

Other Reference CPT Code	Global	Work RVU	Time Source
	090		**RUC Time**

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 42.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 23472**	**Key Reference CPT Code:** 23616	**Source of Time** **RUC Time**
Median Pre-Service Time	75.00	80.00	
Median Intra-Service Time	140.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**448.00**	**413.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.08	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	2.89
Urgency of medical decision making	2.58	3.56
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.08	3.78
Physical effort required	3.75	3.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.42	3.33
Outcome depends on the skill and judgment of physician	4.42	4.22
Estimated risk of malpractice suit with poor outcome	3.42	3.56

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	3.22
Intra-Service intensity/complexity	3.92	3.67
Post-Service intensity/complexity	3.08	3.22

Additional Rationale and Comments

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

Background

CPT code **23472** was included for survey as a family member of new CPT codes **23473**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component*, and **23474**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component*

23473 and 23474, along with CPT codes 24370, *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component* and 24371, *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component* were presented to, and approved by, the CPT Editorial Panel at their October 2011 meeting. The rationale for developing the new codes for total shoulder arthroplasty revision and for total elbow arthroplasty revision was to replace the current coding for these procedures which consisted of billing the total joint implant (23472 and 24363 respectively) with the foreign body removal or implant removal (23331, 23332, and 24160 respectively) with codes for revision of one or both components. This had been requested of the societies by the Centers for Medicare and Medicaid Services (CMS) through written correspondence.

Subsequent to the October 2011 CPT Editorial Panel meeting the new revision codes were forwarded for survey and CMS also asked the societies to survey codes within the respective families. The societies undertook survey efforts for presentation and review at the January 2012 RUC meeting but had collected an insufficient number of surveys for an accurate valuation and at the January 2012 RUC meeting we requested additional time to continue to collect survey responses which was granted and we were able to collect enough additional surveys to provide accurate work RVU recommendations.

CPT code 23472 is a RUC-valued code last surveyed in 1995. The current wRVU is 22.65. Times are 55 minutes pre-service, not broken out, 155 minutes intra-service time, 30 minutes immediate post-service time, 2 inpatient facility visits (1-99232, 1-99231), a full 99238 discharge, and four total post-operative office visits (3-99213, 1-99212) and a total time of 458. The current IWPUT is 0.079.

The AAOS and ASSH conducted a RUC survey and received 28 responses from surgeons without a financial conflict. The median preservice survey times were 45 minutes for pre-service evaluation time, 18 minutes for pre-service positioning time, and 15 minutes scrub, dress and wait. The survey intra-service time was 140 minutes, and immediate post-service time was 30 minutes. The survey respondents overwhelmingly indicated the procedure is performed in inpatient hospital settings and indicated the typical patient stays four days in the facility with one 99232, two 99231 and one 99238 discharge visit assigned. The survey results indicated there are typically four post-operative office visits, three 99213 and one 99212. The survey 25th percentile wRVU was 22.13 and the survey median wRVU was 25.00.

Survey Sample Description
The survey sample for the surveys was derived randomly. The AAOS pulled a random set of 200 orthopaedic surgeons from their member database and then sent all three surveys to this set of 200. The ASSH sent an email to their entire membership asking for members familiar with the procedures and then forwarded the three surveys to any members who indicated experience with the procedures. The ASES sent all three surveys to a random subset of 200 members.

Recommended wRVU and Physician Times

We are recommending a wRVU of 22.13 which is the survey 25th percentile wRVU and less than the current wRVU. We are recommending the pre-service package 4, difficult patient/diffuclt procedure with 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time (12 minutes more than the package and crosswalked from recently valued shoulder codes with the patient positioned beach chair) and 15 minutes pre-service scrub, dress and wait time. We are recommending the survey median intra-service time of 140 minutes and immediate post-service time of 30 minutes. We are recommending the survey post-operative facility visits of 1-99232, 2-99231, and 1-99238 and the survey post-operative office visits of 3-99213 and 1-99212. Total recommended time is 448 minutes with an IWPUT of 0.089.

We believe this is an appropriate value because it is the 25th percentile wRVU; because it fits well in rank order with its key reference service (23616), and because it fits in rank order with other codes in the family, most specifically 23331 and 23332 for which we are recommending slightly lower wRVUs to reflect the intra-service times.

Comparison to Key Reference Service

	CPT	RVW	TOT MIN	Pre-Eval	Pre-Position-ing	Pre-SDW	Intra-Service	Immd Post	# and Level Post Fac	# and Level Fac Discharge	# and Level Post Office
Survey Code	23472	**22.13**	**448**	40	15	20	140	30	1-99232 2-99231	1-99238	3-99213 1-99212
Key Ref Code	23616	**18.37**	**413**	50	15	15	120	30	1-99232 1-	1-99238	3-99213 1-99212

									99231		

23616, Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement is a good comparison code for 23332 with similar, but slightly lower times and a wRVU that is lower to reflect the lower intra-service time for 23616. The total recommended time for 23472 is 448 minutes, which is 35 minutes more than the total time for 23616 with 20 more intra-service minutes and an additional post-operative inpatient facility visit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23472

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

Specialty orthopaedic surgery How often? Commonly

Specialty hand surgery How often? Sometimes

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,115 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Website: 2010 Medicare final utilization for CY 2012 PFS for CPT code 23331 minus the estimated utilization of 23473 because 23331 will no longer be allowed to be billed for a Total Shoulder Arthroplasty

Specialty orthopaedic surgery Frequency 22239 Percentage 96.21 %

Specialty hand surgery Frequency 734 Percentage 3.17 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 23472

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23473 Tracking Number E4 Original Specialty Recommended RVU: **25.00**
Presented Recommended RVU: **25.00**
Global Period: 090 RUC Recommended RVU: **25.00**

CPT Descriptor: Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female is 17 years following a total shoulder arthroplasty and has pain and limited motion with radiographic evidence of component loosening. She undergoes revision of the humeral component.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning - position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a deltopectoral incision is made from the mid clavicle to the junction to the mid-third of the humerus. The deltopectoral interval is opened allowing identification of the conjoined tendon. Careful protection around neurovascular structures during the case including the axillary and musculocutaneous nerve is imperative. The subscapularis tendon is divided , tagged and mobilized. A wide capsular release is performed for exposure and mobilization of the proximal humerus. Dislocation of the shoulder components is performed with intraoperative inspection and assessment of the humeral component. Extensive scar tissue is excised. Extraction instruments are used to remove the loose humeral component and loose glenoid component. Meticulous preparation and cleaning of the humeral canal, including removal of the fibrous membrane and all of the cement is performed. The wound is irrigated with liters of antibiotic fluid. Cementing or press-fit with or without bone graft of the humeral component within the humeral shaft is done. Judgment and technical skill are necessary to carefully align the humeral component in the proper height and degree of retroversion to prevent postoperative subluxation or dislocation. Reattachment of the subscapularis tendon is next done followed by re-approximation of the deltopectoral interval and closure of the subcutaneous tissue and skin.

Description of Post-Service Work:
Hospital - through discharge from recovery room: Apply sterile dressings. The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity to ensure that no brachial plexus injury has occurred during surgery. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise, indicating avoidance of passive stretching of the shoulder. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic shoulder. Write orders for progression to active exercise depending on the quality of the rotator cuff tissues and the adequacy of the rotator cuff repair. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	William Creevy, MD; John Heiner, MD; Daniel Nagle, MD; Anne Miller, MD		
Specialty(s):	orthopaedic surgery, hand surgery		
CPT Code:	23473		
Sample Size: 400	**Resp N:** 28	**Response:** 7.0 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	30.00
Survey RVW:	19.00	25.00	**30.00**	36.25	55.00
Pre-Service Evaluation Time:			**58.00**		
Pre-Service Positioning Time:			**18.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	100.00	144.00	**180.00**	185.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23473	**Recommended Physician Work RVU: 25.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23210	090	27.21	**RUC Time**

CPT Descriptor Radical resection of tumor; scapula

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.79	**RUC Time**	12,731

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63051	090	25.51	**RUC Time**	781

CPT Descriptor 2 Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

Other Reference CPT Code	Global	Work RVU	Time Source
	090		**RUC Time**

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 32.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 23473**	**Key Reference CPT Code:** 23210	**Source of Time** **RUC Time**
Median Pre-Service Time	75.00	80.00	
Median Intra-Service Time	180.00	210.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**488.00**	**560.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.50	5.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	5.00
Urgency of medical decision making	2.63	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.88	4.75
Physical effort required	4.88	5.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.88	5.00
Outcome depends on the skill and judgment of physician	4.88	5.00
Estimated risk of malpractice suit with poor outcome	4.00	4.25

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.50	4.75
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	4.13	4.75

Additional Rationale and Comments

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

Background

CPT codes **23473**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component*, and **23474**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND*

glenoid component, along with CPT codes 24370, *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component* and 24371, *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component* were presented to, and approved by, the CPT Editorial Panel at their October 2011 meeting. The rationale for developing the new codes for total shoulder arthroplasty revision and for total elbow arthroplasty revision was to replace the current coding for these procedures which consisted of billing the total joint implant (23472 and 24363 respectively) with the foreign body removal or implant removal (23331, 23332, and 24160 respectively) with codes for revision of one or both components. This had been requested of the societies by the Centers for Medicare and Medicaid Services (CMS) through written correspondence.

Subsequent to the October 2011 CPT Editorial Panel meeting the new revision codes were forwarded for survey and CMS also asked the societies to survey codes within the respective families. The societies undertook survey efforts for presentation and review at the January 2012 RUC meeting but had collected an insufficient number of surveys for an accurate valuation and at the January 2012 RUC meeting we requested additional time to continue to collect survey responses which was granted and we were able to collect enough additional surveys to provide accurate work RVU recommendations.

The AAOS and ASSH conducted a RUC survey and received 28 responses from surgeons without a financial conflict. The median preservice survey times were 58 minutes for pre-service evaluation time, 18 minutes for pre-service positioning time, and 15 minutes scrub, dress and wait. The survey intra-service time was 180 minutes, and immediate post-service time was 30 minutes. The survey respondents overwhelmingly indicated the procedure is performed in inpatient hospital settings and indicated the typical patient stays four days in the facility with one 99232, two 99231 and one 99238 discharge visit assigned. The survey results indicated there are typically four post-operative office visits, three 99213 and one 99212. The survey 25th percentile wRVU was 25.00 and the survey median wRVU was 30.00.

Survey Sample Description
The survey sample for the surveys was derived randomly. The AAOS pulled a random set of 200 orthopaedic surgeons from their member database and then sent all three surveys to this set of 200. The ASSH sent an email to their entire membership asking for members familiar with the procedures and then forwarded the three surveys to any members who indicated experience with the procedures. The ASES sent all three surveys to a random subset of 200 members.

Recommended wRVU and Physician Times

We are recommending a wRVU of 25.00 which is the survey 25th percentile wRVU. We are recommending the pre-service package 4, difficult patient/diffuclt procedure with 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time (12 minutes more than the package and crosswalked from recently valued shoulder codes with the patient positioned beach chair) and 15 minutes pre-service scrub, dress and wait time. We are recommending the survey median intra-service time of 180 minutes and immediate post-service time of 30 minutes. We are recommending the survey post-operative facility visits of 1-99232, 2-99231, and 1-99238 and the survey post-operative office visits of 3-99213 and 1-99212. Total recommended time is 488 minutes with an IWPUT of 0.085.

We believe this is an appropriate value because it is the 25th percentile wRVU and it fits well in rank order with its key reference service (23310), this also aligns with other codes in the family, most specifically 23472 for which we are recommending a lower wRVU than 23473 to reflect the lower intra-service time and 23474 for which we are recommending a wRVU higher than 23473 to reflect the higher intra-service time.

A wRVU of 25.00 is also less than what the current wRVUs. The procedure is currently coded 23472 (22.65 wRVU) + 23331-51 modifier (7.63/2=3.82wRVU) which is a total of 26.47 wRVU.

Comparison to Key Reference Service

	CPT	RVW	TOT MIN	Pre-Eval	Pre-Position-ing	Pre-SDW	Intra-Service	Immd Post	# and Level Post Fac	# and Level Fac Discharge	# and Level Post Office
Survey Code	23473	**25.00**	**488**	40	15	20	180	30	1-99232 2-99231	1-99238	3-99213 1-99212
Key Ref Code	23210	**27.21**	**560**	40	20	20	210	30	2-99232 1-99231	1-99238	1-99214 2-99213 1-99212

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23472 and 23331

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

Specialty orthopaedic surgery How often? Sometimes

Specialty hand surgery How often? Rarely

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 650
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We arrived at the estimate by looking first at the 2010 Medicare utilization for CPT code 23472, Total Shoulder Arthroplasty which was 24,415. The third most common ICD-9 diagnosis code was ICD-9 code 996 which is for complication of a specific procedure and it was listed for 4.3% of the 23472's in 2010. 4.3% of 24,415 equals approximately 1,050. Next, we assumed that of those 1,050 revisions approximately half were for one component (23473) and half were for both components (23474) which would mean 525 for each. We then added another 125 procedures to account for the potential other 23472s that may have actually been revisions but had a different ICD-9 code attached to them.

Specialty orthopaedic surgery Frequency 620 Percentage 95.38 %

Specialty hand surgery Frequency 30 Percentage 4.61 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 23472

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23474 Tracking Number E5 Original Specialty Recommended RVU: **27.21**
Presented Recommended RVU: **27.21**
Global Period: 090 RUC Recommended RVU: **27.21**

CPT Descriptor: Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female is 17 years following a total shoulder arthroplasty and has pain and limited motion with radiographic evidence of component loosening. She undergoes revision of both the humeral and glenoid components.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning - position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a deltopectoral incision is made from the mid clavicle to the junction to the mid-third of the humerus. The deltopectoral interval is opened allowing identification of the conjoined tendon. Careful protection around neurovascular structures during the case including the axillary and musculocutaneous nerve is imperative. The subscapularis tendon is divided , tagged and mobilized. A wide capsular release is performed for exposure and mobilization of the proximal humerus. Dislocation of the shoulder components is performed with intraoperative inspection and assessment of the humeral and glenoid components. Extensive scar tissue is excised. Extraction instruments are used to remove the loose humeral component and loose glenoid component. Meticulous preparation and cleaning of the humeral canal, including removal of the fibrous membrane and all of the cement is performed. Meticulous preparation and cleaning of the glenoid, including removal of the fibrous membrane and all of the cement is performed. The wound is irrigated with liters of antibiotic fluid. The glenoid fossa is carefully prepared to accept a properly aligned glenoid component, with or without bone graft. This component is fixed in place with cement or screws. Judgment and technical

skill are necessary to carefully align the glenoid component in the proper position and version to prevent postoperative subluxation or dislocation Cementing or press-fit with or without bone graft of the humeral component within the humeral shaft is done. Judgment and technical skill are necessary to carefully align the humeral component in the proper height and degree of retroversion to prevent postoperative subluxation or dislocation. Reattachment of the subscapularis tendon is next done followed by re-approximation of the deltopectoral interval and closure of the subcutaneous tissue and skin.

Description of Post-Service Work:
Hospital - through discharge from recovery room: Apply sterile dressings. The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity to ensure that no brachial plexus injury has occurred during surgery. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise, indicating avoidance of passive stretching of the shoulder. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic shoulder. Write orders for progression to active exercise depending on the quality of the rotator cuff tissues and the adequacy of the rotator cuff repair. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	William Creevy, MD; John Heiner, MD; Daniel Nagle, MD; Anne Miller, MD		
Specialty(s):	orthopaedic surgery, hand surgery		
CPT Code:	23474		
Sample Size: 400	**Resp N:** 28	**Response:** 7.0 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	20.00	30.00
Survey RVW:	21.50	31.50	**35.00**	45.00	60.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**18.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	145.00	180.00	**205.00**	240.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23474	**Recommended Physician Work RVU: 27.21**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**205.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23220	090	30.21	**RUC Time**

CPT Descriptor Radical resection of tumor, proximal humerus

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63051	090	25.51	**RUC Time**	781

CPT Descriptor 1 Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44626	090	27.90	**RUC Time**	4,250

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

Other Reference CPT Code	Global	Work RVU	Time Source
23210	090	27.21	**RUC Time**

CPT Descriptor Radical resection of tumor; scapula

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 32.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 23474**	**Key Reference CPT Code:** 23220	**Source of Time RUC Time**
Median Pre-Service Time	75.00	72.00	
Median Intra-Service Time	205.00	240.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**513.00**	**602.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.17
Urgency of medical decision making	2.50	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.88	5.00
Physical effort required	4.50	4.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.63	4.83
Outcome depends on the skill and judgment of physician	4.63	4.67
Estimated risk of malpractice suit with poor outcome	3.88	3.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.38	4.33
Intra-Service intensity/complexity	4.75	4.50
Post-Service intensity/complexity	3.63	4.00

Additional Rationale and Comments

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

Background

CPT codes **23473**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component*, and **23474**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND*

glenoid component, along with CPT codes 24370, *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component* and 24371, *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component* were presented to, and approved by, the CPT Editorial Panel at their October 2011 meeting. The rationale for developing the new codes for total shoulder arthroplasty revision and for total elbow arthroplasty revision was to replace the current coding for these procedures which consisted of billing the total joint implant (23472 and 24363 respectively) with the foreign body removal or implant removal (23331, 23332, and 24160 respectively) with codes for revision of one or both components. This had been requested of the societies by the Centers for Medicare and Medicaid Services (CMS) through written correspondence.

Subsequent to the October 2011 CPT Editorial Panel meeting the new revision codes were forwarded for survey and CMS also asked the societies to survey codes within the respective families. The societies undertook survey efforts for presentation and review at the January 2012 RUC meeting but had collected an insufficient number of surveys for an accurate valuation and at the January 2012 RUC meeting we requested additional time to continue to collect survey responses which was granted and we were able to collect enough additional surveys to provide accurate work RVU recommendations.

The AAOS and ASSH conducted a RUC survey and received 28 responses from surgeons without a financial conflict. The median pre-service survey time was 60 minutes for pre-service evaluation time, 18 minutes for pre-service positioning time, and 15 minutes scrub, dress and wait. The survey intra-service time was 205 minutes, and immediate post-service time was 30 minutes. The survey respondents overwhelmingly indicated the procedure is performed in inpatient hospital settings and indicated the typical patient stays four days in the facility with one 99232, two 99231 and one 99238 discharge visit assigned. The survey results indicated there are typically four post-operative office visits, three 99213 and one 99212. The survey 25th percentile wRVU was 31.50 and the survey median wRVU was 35.00.

Survey Sample Description
The survey sample for the surveys was derived randomly. The AAOS pulled a random set of 200 orthopaedic surgeons from their member database and then sent all three surveys to this set of 200. The ASSH sent an email to their entire membership asking for members familiar with the procedures and then forwarded the three surveys to any members who indicated experience with the procedures. The ASES sent all three surveys to a random subset of 200 members.

Recommended wRVU and Physician Times

We are recommending a wRVU of 27.21 which is a direct crosswalk from the reference code of 23210 with a wRVU of 27.21 minutes. We are recommending the pre-service package 4, difficult patient/diffuclt procedure with 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time (12 minutes more than the package and crosswalked from recently valued shoulder codes with the patient positioned beach chair) and 15 minutes pre-service scrub, dress and wait time. We are recommending the survey median intra-service time of 205 minutes and immediate post-service time of 30 minutes. We are recommending the survey post-operative facility visits of 1-99232, 2-99231, and 1-99238 and the survey post-operative office visits of 3-99213 and 1-99212. Total recommended time is 513 minutes with an IWPUT of 0.086.

We believe this is an appropriate value because of the similarities between the surveyed times for 23474 and reference code 23310 and because our expert consensus panel did not feel the 25th% survey wRVU or the survey median wRVU were appropriate. 23474 has 205 minutes of intra-service time and 23210 has an intra-service time of 210 minutes and the total pre-service times are very similar, and the immediate post-service time is identical. 23210 has more time in the post-operative period but this is from higher levels of post-operative facility and office visits and not because of more post-operative facility and office visits. Thus, a wRVU of 27.21 maintains a correct rank order with reference code 23210 and also fits at the top of the family of should implant removal and total shoulder procedure codes.

A wRVU of 27.21 is also less than the current wRVUs. The procedure is currently coded with 23472 (22.65 wRVU) + 23332-51 modifier (12.37/2=6.19wRVU) which is a total of 28.84 wRVU.

Comparison to Key Reference Service

	CPT	RVW	TOT MIN	Pre-Eval	Pre-Position-ing	Pre-SDW	Intra-Service	Immd Post	# and Level Post Fac	# and Level Fac Discharge	# and Level Post Office
Survey Code	23474	**27.21**	**503**	40	15	20	205	30	1-99232 2-99231	1-99238	3-99213 1-99212

CPT Code: 23474

Key Ref Code	23210	**27.21**	**560**	40	20	20	210	30	2-99232 2-99231	1-99238	1-99214 2-99213 1-99212

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23472 and 23332

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

Specialty orthopaedic surgery How often? Sometimes

Specialty hand surgery How often? Rarely

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 650
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. We arrived at the estimate by looking first at the 2010 Medicare utilization for CPT code 23472, Total Shoulder Arthroplasty which was 24,415. The third most common ICD-9 diagnosis code was ICD-9 code 996 which is for complication of a specific procedure and it was listed for 4.3% of the 23472's in 2010. 4.3% of 24,415 equals approximately 1,050. Next, we assumed that of those 1,050 revisions approximately half were for one component (23473) and half were for both components (23474) which would mean 525 for each. We then added another 125 procedures to account for the potential other 23472s that may have actually been revisions but had a different ICD-9 code attached to them.

Specialty orthopaedic surgery Frequency 620 Percentage 95.38 %

Specialty hand surgery Frequency 30 Percentage 4.61 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 23210

SS Rec Summary

ISSUE: Shoulder Arthroplasty and Implant Removal

TAB: 4

					RVW					Total	PRE			INTRA					POST-FACILITY						POST-OFFICE					
	SOURCE	CPT	DESC	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	38	39	15	14	13	12	11
7	**REF**	**23616**	Open treatment of proximal humeral (surgica	**0.078**			**18.37**			**413**	50	15	15			120			30		1	1.0	1.0				3	1		
8	**2000**	**23472**	Arthroplasty, glenohumeral joint; total should	**0.079**			**22.65**			**458**	**60**					**165**			**30**		**1**	**2**	**1.0**				**3**	**1**		
9	**SVY**	**23472**	Arthroplasty, glenohumeral joint; total should	**0.109**	**18.00**	**22.13**	**25.00**	**30.13**	**50.00**	**451**	**45**	**18**	**15**	**120**	**120**	**140**	**150**	**180**	**30**		**1**	**2**	**1.0**				**3**	**1**		
10	**REC**	**23472**	25th percentile RVW	**0.089**			**22.13**			**448**	**40**	**15**	**20**			**140**			**30**		**1**	**2**	**1.0**				**3**	**1**		
11																														
12	**REF**	**23210**	Radical resection of tumor; scapula	**0.078**			**27.21**			**560**	40	20	20			210			30		2	1.0	1.0			1	2	1		
13	**2000**	**23472**	Arthroplasty, glenohumeral joint; total should	**0.079**			**22.65**			**458**	**60**					**165**			**30**		**1**	**2**	**1.0**				**3**	**1**		
14	**HVD**	**23331**	Removal of foreign body, shoulder; deep (eg	**0.032**			**7.63**			**273**	**25**	**0**	**25**			**88**			**23**			**0.5**	**1.0**					**4**		
15	***Current Value with 23472 and 23331-51 modifier***						**26.47**																							
16	**SVY**	**23473**	Revision of total shoulder arthroplasty, includ	**0.111**	**19.00**	**25.00**	**30.00**	**36.25**	**55.00**	**504**	**58**	**18**	**15**	**100**	**144**	**180**	**185**	**240**	**30**		**1**	**2**	**1.0**				**3**	**1**		
17	**REC**	**23473**	25th percentile RVW	**0.085**			**25.00**			**488**	**40**	**15**	**20**			**180**			**30**		**1**	**2**	**1.0**				**3**	**1**		
18																														
19	**REF**	**23210**	Radical resection of tumor; scapula	**0.078**			**27.21**			**560**	40	20	20			210			30		2	1.0	1.0			1	2	1		
20	**2000**	**23472**	Arthroplasty, glenohumeral joint; total should	**0.079**			**22.65**			**458**	**60**					**165**			**30**		**1**	**2**	**1.0**				**3**	**1**		
21	**HVD**	**23332**	Removal of foreign body, shoulder; complica	**0.031**			**12.37**			**410**	**30**	**0**	**25**			**129**			**26**			**4.5**	**1.0**					**4.5**		
22	***Current Value with 23472 and 23331-51 modifier***						**28.84**																							
23	**SVY**	**23474**	Revision of total shoulder arthroplasty, includ	**0.121**	**21.50**	**31.50**	**35.00**	**45.00**	**60.00**	**531**	**60**	**18**	**15**	**145**	**180**	**205**	**240**	**360**	**30**		**1**	**2**	**1.0**				**3**	**1**		
24	**REC**	**23474**	Crosswalk to 23210	**0.086**			**27.21**			**513**	**40**	**15**	**20**			**205**			**30**		**1**	**2**	**1.0**				**3**	**1**		

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

CPT Long Descriptor:
23331, Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)
23332, Removal of foreign body, shoulder; complicated (eg, total shoulder)
23472, Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
23473, Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component
23474, Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component

Global Period: 090 Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A consensus expert panel committee was convened and reviewed the procedure under review. The consensus panel compared the current PE details for 23331, 23332 and 23472 and determined no changes beyond changes in post-operative service time where the level and/or number of post-operative office visits were warranted. Otherwise, standard 090 facility inputs were used for the existing codes as well as the new codes.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: Consensus committee reviewed current PE details as comparison codes for both the existing and the new codes as these are the most relevant to the existing and new code descriptors.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard pre-service clinical labor activities for 090-day global facility codes

Intra-Service Clinical Labor Activities:

Standard intra-service clinical labor activities for 090-day global facility codes

Post-Service Clinical Labor Activities:

Standard post-service clinical labor activities for 090-day global facility codes

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
2				23331 90-day Std.		23331		23332 90-day Std.		23332	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)		Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)		Removal of foreign body, shoulder; complicated (eg, total shoulder)		Removal of foreign body, shoulder; complicated (eg, total shoulder)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**180**	**N/A**	**180**	**N/A**	**194**	**N/A**	**194**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**108**	**N/A**	**108**	**N/A**	**122**	**N/A**	**122**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA		**5**		**5**		**5**		**5**
13	Coordinate pre-surgery services		RN/LPN/MTA		**20**		**20**		**20**		**20**
14	Schedule space and equipment in facility		RN/LPN/MTA		**8**		**8**		**8**		**8**
15	Provide pre-service education/obtain consent		RN/LPN/MTA		**20**		**20**		**20**		**20**
16	Follow-up phone calls & prescriptions		RN/LPN/MTA		**7**		**7**		**7**		**7**
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)		RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16								
48	99212 27 minutes		27		**4**		**4**		**4.5**		**4.5**
49	99213 36 minutes		36								
50	99214 53 minutes		53								
51	99215 63 minutes		63								
52	**Total Office Visit Time**		RN/LPN/MTA	**0**	**108**	**0**	**108**	**0**	**122**	**0**	**122**
54	**End: with last office visit before end of global period**										
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
56	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**		**5**		**5**
57	pack, post-op incision care (staple)	SA052	pack		**1**				**1**		
58	pack, post-op incision care (suture & staple)	SA053	pack				**1**				**1**
59	**EQUIPMENT**	**CODE**									
60	table, power	EF031	10		**108**		**108**		**122**		**122**
61	light, exam	EQ168	10				**108**				**122**
62	cast cutter	EQ081	10		**108**				**122**		

	A	B	C	L	M	N	O	P	Q	R	S	T	U	V	W
1					REFERENCE CODE				REFERENCE CODE				REFERENCE CODE		
2				23472 PEAC 2002		23472		23472 PEAC 2002		23473		23472 PEAC 2002		23474	
3	**Meeting Date: April 2012** **Tab:** **Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA		**5**		**5**		**5**		**5**		**5**		**5**
13	Coordinate pre-surgery services		RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
14	Schedule space and equipment in facility		RN/LPN/MTA		**8**		**8**		**8**		**8**		**8**		**8**
15	Provide pre-service education/obtain consent		RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
16	Follow-up phone calls & prescriptions		RN/LPN/MTA		**7**		**7**		**7**		**7**		**7**		**7**
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)		RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16												
48	99212 27 minutes		27		**1**		**1**		**1**		**1**		**1**		**1**
49	99213 36 minutes		36		**3**		**3**		**3**		**3**		**3**		**3**
50	99214 53 minutes		53												
51	99215 63 minutes		63												
52	**Total Office Visit Time**		RN/LPN/MTA	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**
54	**End: with last office visit before end of global period**														
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**		**4**		**4**		**4**		**4**
57	pack, post-op incision care (staple)	SA052	pack		**1**		**1**		**1**		**1**		**1**		**1**
58	pack, post-op incision care (suture & staple)	SA053	pack				**0**				**0**				**0**
59	**EQUIPMENT**	**CODE**													
60	table, power	EF031	10		**135**		**135**		**135**		**135**		**135**		**135**
61	light, exam	EQ168	10				**135**				**135**				**135**
62	cast cutter	EQ081	10												

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
2				23331 90-day Std.		23331		23332 90-day Std.		23332	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)		Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)		Removal of foreign body, shoulder; complicated (eg, total shoulder)		Removal of foreign body, shoulder; complicated (eg, total shoulder)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**180**	**N/A**	**180**	**N/A**	**194**	**N/A**	**194**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**108**	**N/A**	**108**	**N/A**	**122**	**N/A**	**122**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA		**5**		**5**		**5**		**5**
13	Coordinate pre-surgery services		RN/LPN/MTA		**20**		**20**		**20**		**20**
14	Schedule space and equipment in facility		RN/LPN/MTA		**8**		**8**		**8**		**8**
15	Provide pre-service education/obtain consent		RN/LPN/MTA		**20**		**20**		**20**		**20**
16	Follow-up phone calls & prescriptions		RN/LPN/MTA		**7**		**7**		**7**		**7**
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)		RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16								
48	99212 27 minutes		27		**4**		**4**		**4.5**		**4.5**
49	99213 36 minutes		36								
50	99214 53 minutes		53								
51	99215 63 minutes		63								
52	**Total Office Visit Time**		RN/LPN/MTA	**0**	**108**	**0**	**108**	**0**	**122**	**0**	**122**
54	**End: with last office visit before end of global period**										
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
56	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**		**5**		**5**
57	pack, post-op incision care (staple)	SA052	pack		**1**				**1**		
58	pack, post-op incision care (suture & staple)	SA053	pack				**1**				**1**
59	**EQUIPMENT**	**CODE**									
60	table, power	EF031	10		**108**		**108**		**122**		**122**
61	light, exam	EQ168	10				**108**				**122**
62	cast cutter	EQ081	10		**108**				**122**		

	A	B	C	L	M	N	O	P	Q	R	S	T	U	V	W
1					REFERENCE CODE				REFERENCE CODE				REFERENCE CODE		
2				23472 PEAC 2002		23472		23472 PEAC 2002		23473		23472 PEAC 2002		23474	
3	**Meeting Date: April 2012** **Tab:** **Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total		Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		RN/LPN/MTA	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA		**5**		**5**		**5**		**5**		**5**		**5**
13	Coordinate pre-surgery services		RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
14	Schedule space and equipment in facility		RN/LPN/MTA		**8**		**8**		**8**		**8**		**8**		**8**
15	Provide pre-service education/obtain consent		RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
16	Follow-up phone calls & prescriptions		RN/LPN/MTA		**7**		**7**		**7**		**7**		**7**		**7**
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)		RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16												
48	99212 27 minutes		27		**1**		**1**		**1**		**1**		**1**		**1**
49	99213 36 minutes		36		**3**		**3**		**3**		**3**		**3**		**3**
50	99214 53 minutes		53												
51	99215 63 minutes		63												
52	**Total Office Visit Time**		RN/LPN/MTA	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**
54	**End: with last office visit before end of global period**														
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**		**4**		**4**		**4**		**4**
57	pack, post-op incision care (staple)	SA052	pack		**1**				**1**				**1**		
58	pack, post-op incision care (suture & staple)	SA053	pack				**1**				**1**				**1**
59	**EQUIPMENT**	**CODE**													
60	table, power	EF031	10		**135**		**135**		**135**		**135**		**135**		**135**
61	light, exam	EQ168	10				**135**				**135**				**135**
62	cast cutter	EQ081	10												

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Elbow Arthroplasty and Implant Removal

In October 2011, the CPT Editorial Panel created two new CPT codes for revision of a total elbow arthroplasty, CPT code 24370 *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component* and CPT code 24371 *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component.* The new codes were created because of a CCI edit stating that providers could no longer report implant removal and total elbow arthroplasty when a revision arthroplasty was performed. The specialty societies surveyed for the January 2012 RUC meeting, but were not able to collect a sufficient number of surveys for an accurate review and valuation. In January 2012 the RUC approved the specialty society's request to continue collecting survey responses. CMS requested surveys for all base and family codes, including CPT code 24160 *Implant removal; elbow joint* (work RVU=8.00) and CPT code 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow*) (work RVU=22.65). These procedures are low volume and as a result have low survey response, however the RUC agreed that enough additional surveys were collected for the specialty societies to present work RVU recommendations at the April 2012 RUC meeting.

24160 *Implant removal; elbow joint*
The RUC reviewed the survey results and determined the current code descriptor is non-specific to the type of implant removed. **The RUC recommends that the current work RVU of 8.00 be maintained for CPT code 24160 and that the code be referred to CPT for revision of the description.**

24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)*
The RUC reviewed the survey results and recommends a work RVU of 22.00, the survey's 25th percentile, less than the current work RVU of 22.65. The RUC compared 24363 to key reference service 24150 *Radical resection of tumor, shaft or distal humerus* (work RVU=23.46) and determined that the reference code has 40 minutes more intraservice time, justifying the higher work RVU. The RUC also compared 24363 to CPT code 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* (work RVU=21.79), and noted that these services have almost identical intraservice time at 140 and 135, respectively, therefore the recommended work RVU maintains the proper relativity among similar arthroplasty services. **The RUC recommends a work RVU of 22.00 for CPT code 24363.**

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24370 *Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component*
The RUC reviewed the survey results and recommends a work RVU of 23.55, the survey's 25th percentile. CPT code 24370 is revision of one side of the elbow and is performed less commonly than 24371, which is revision of both sides. The RUC compared 24370 to 24150 *Radical resection of tumor, shaft or distal humerus* (work RVU=23.46) and noted that these services have almost identical intraservice time 175 and 180, respectively, however, the complexity and intensity of work to remove and replace the elbow joint is greater than the work to resect a tumor from a bone. The recommended work RVU maintains the proper relativity among similar arthroplasty services and excision procedures. **The RUC recommends a work RVU of 23.55 for CPT code 24370.**

24371 *Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component*
The RUC reviewed the survey and recommends a work RVU of 27.50, the survey's 25th percentile. The RUC discussed changes in the work involved in this service and agreed that there have been significant changes in the removal of the prosthesis with cemented components, which is an integral part of this procedure, consistent with the increase in RVUs. It was also noted that the procedure involves removing the prosthesis as well as preserving what is necessary to complete a replacement arthroplasty, and this is the most intense time in the procedure. The RUC compared 24371 to 23210 *Radical resection of tumor; scapula* (work RVU=27.21) and noted that these services have identical intraservice time and should be valued similarly. **The RUC recommends a work RVU of 27.50 for CPT code 24371.**

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

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

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
24160	F1	Implant removal; elbow joint (Do not report 24160 in conjunction with 24370 or 24371 if a prosthesis [ie, humeral and/or ulnar component(s)] is being removed and replaced in the same elbow)	090	8.00 (No Change) (Refer to CPT Editorial Panel)
24363	F2	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) (For revision of total elbow implant, see 24370, 24371)	090	22.00
●24370	F3	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component	090	23.55
●24371	F4	humeral and ulnar component (Do not report 24370-24371 in conjunction with 24160 if a prosthesis [ie, humeral and/or ulnar component(s)] is being removed and replaced in the same elbow)	090	27.50

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24363 Tracking Number F2 Original Specialty Recommended RVU: **22.50**
Presented Recommended RVU: **22.00**
Global Period: 090 RUC Recommended RVU: **22.00**

CPT Descriptor: Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old female undergoes total elbow replacement with humeral and ulnar replacement for rheumatoid arthritis..

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning in a lateral decubitus position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a posterior elbow incision is made. The ulnar nerve is identified for protection throughout the dissection. The triceps and extensor mechanism are released from a near insertion on the ulna and then displaced in a radial direction. The elbow joint is exposed and the synovium and capsule are released from the humerus with excision of the excess synovium after exposing the whole elbow joint. A burr and saw along with cutting guides are used to cut the proximal ulna and the distal humerus and a total elbow arthroplasty is performed using the technique as described. After trial components are inserted in a correct position, the final components are inserted using methylmethacrylate in order to complete the procedure. Extra bone is placed about the prosthesis as needed. The tourniquet is released, hemostasis is obtained, and the triceps tendon is re-approximated to the proximal ulna. The remainder of the extensor mechanism is approximated, subcutaneous tissue approximated, and the skin is closed..

Description of Post-Service Work: Hospital - through discharge from recovery room: Apply sterile dressings and splint. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss

procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic elbow. Write orders for progression to active exercise. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples and sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	William Creevy, MD; John Heiner, MD; Daniel Nagle, MD; Anne Miller, MD		
Specialty(s):	orthopaedic surgery; hand surgery		
CPT Code:	24363		
Sample Size: 400	**Resp N:** 26	**Response:** 6.5 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**5.00**	8.00	14.00
Survey RVW:	18.00	22.00	**22.50**	27.25	40.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	100.00	120.00	**140.00**	150.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	24363	**Recommended Physician Work RVU: 22.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**140.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24150	090	23.46	**RUC Time**

CPT Descriptor Radical resection of tumor, shaft or distal humerus

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45400	090	19.44	**RUC Time**	253

CPT Descriptor 1 Laparoscopy, surgical; proctopexy (for prolapse))

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.69	**RUC Time**	12,731

CPT Descriptor 2 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

Other Reference CPT Code	Global	Work RVU	Time Source
	090		**RUC Time**

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 26.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 24363**	**Key Reference CPT Code:** 24150	**Source of Time** **RUC Time**
Median Pre-Service Time	72.00	72.00	
Median Intra-Service Time	140.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**445.00**	**522.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	3.50
Urgency of medical decision making	2.14	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.86	3.67
Physical effort required	3.86	3.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.71	3.67
Outcome depends on the skill and judgment of physician	3.86	3.67
Estimated risk of malpractice suit with poor outcome	3.71	3.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.57	3.67
Intra-Service intensity/complexity	4.00	3.83
Post-Service intensity/complexity	3.29	3.17

Additional Rationale and Comments

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

Background

CPT code **24363** was included for survey as a family member of new CPT codes **24370**, *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component*, and **24371**, *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component*

24370 and 24371 along with **24373**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component*, and **24374**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component* were presented to, and approved by, the CPT Editorial Panel at their October 2011 meeting. The rationale for developing the new codes for total shoulder arthroplasty revision and for total elbow arthroplasty revision was to replace the current coding for these procedures which consisted of billing the total joint implant (23472 and 24363 respectively) with the foreign body removal or implant removal (23331, 23332, and 24160 respectively) with codes for revision of one or both components. This had been requested of the societies by the Centers for Medicare and Medicaid Services (CMS) through written correspondence.

Subsequent to the October 2011 CPT Editorial Panel meeting the new revision codes were forwarded for survey and CMS also asked the societies to survey codes within the respective families. The societies undertook survey efforts for presentation and review at the January 2012 RUC meeting but had collected an insufficient number of surveys for an accurate valuation and at the January 2012 RUC meeting we requested additional time to continue to collect survey responses which was granted and we were able to collect enough additional surveys to provide accurate work RVU recommendations.

CPT code 24363 is a RUC valued code that was last surveyed and revalued in 2005 as part of the 3rd 5-Year review. The current work RVU is 22.62 with pre-service evaluation and SDW combined time of 50 minutes, 17.50 minutes of pre-service positioning, 150 minutes of intra-service time, 30 minutes immediate post-service time, 3 total inpatient facility visits (1-99232, 2-99231), one full inpatient facility discharge (99238) and four post-operative office visits (3-99213, 1-99212).

The AAOS and ASSH conducted a RUC survey and received 26 responses from surgeons without a financial conflict. The median preservice survey times were 45 minutes for pre-service evaluation time, 15 minutes for pre-service positioning time, and 15 minutes scrub, dress and wait. The survey intra-service time was 140 minutes, and immediate post-service time was 30 minutes. The survey respondents overwhelmingly indicated the procedure is performed in inpatient hospital settings and indicated the typical patient stays three days in the facility with one 99232, two 99231, plus a full hospital facility discharge (99238). The survey results indicated there are typically four post-operative office visits, three 99213 and one 99212.

Survey Sample Description
The survey sample for the surveys was derived randomly. The AAOS pulled a random set of 200 orthopaedic surgeons from their member database and then sent all three surveys to this set of 200. The ASSH sent an email to their entire membership asking for members familiar with the procedures and then forwarded the three surveys to any members who indicated experience with the procedures. The ASES sent all three surveys to a random subset of 200 members.

Recommended wRVU and Physician Times

We are recommending a wRVU of 22.50 which is the survey median wRVU and less than the current value of 22.65. We are recommending the pre-service package 4, difficult patient/diffuclt procedure with 40 minutes pre-service evaluation time, 12 minutes pre-service positioning time (9 minutes more than the package and crosswalked from recently valued elbow codes with the patient positioned lateral decubitus) and 15 minutes pre-service scrub, dress and wait time. We are recommending the survey median intra-service time of 140 minutes and immediate post-service time of 30 minutes. We are recommending the survey post-operative facility visits of 1-99232, 2-99231, and 1-99238 and the survey post-operative office visits of 3-99213 and 1-99212. Total recommended time is 445 minutes.

We believe this is an appropriate value because it is the survey median wRVU and the recommended value is very similar (but very slightly lower) than the current wRVU. In comparison to the current wRVU and times, our recommended wRVU is very slightly lower (22.50 compared to 22.65) which we believe is appropriate because the total times are essentially identical as well (445 compared to 448). The current IWPUT is 0.091 and the recommended IWPUT is 0.089.

Comparison to Key Reference Service

	CPT	RVW	TOT MIN	Pre-Eval	Pre-Position-ing	Pre-SDW	Intra-Service	Immd Post	# and Level Post Fac	# and Level Fac Discharge	# and Level Post Office
Survey Code	24363	**22.50**	**445**	40	12	20	140	30	1-99232 2-99231	1-99238	3-99213 1-99212

CPT Code: 24363

Key Ref Code	24150	**23.46**	**522**	40	12	15	180	30	2-99232 1-99231	1-99238	3-99213 1-99212

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24363

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

Specialty orthopaedic surgery How often? Sometimes

Specialty hand surgery How often? Rarely

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 832
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Website: 2010 Medicare final utilization for CY 2012 PFS for 24363 (979) subtracting the total number of total elbow arthroplasty revision codes we are assuming will be performed which is roughly 147 (24370 and 24371) because those will no longer will be billed under 24363 leaving approximately 832 total elbow arthroplasty codes done a year

Specialty orthopaedic surgery Frequency 652 Percentage 78.36 %

Specialty hand surgery Frequency 163 Percentage 19.59 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 24363

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24370 Tracking Number F3 Original Specialty Recommended RVU: **23.55**
Presented Recommended RVU: **23.55**
Global Period: 090 RUC Recommended RVU: **23.55**

CPT Descriptor: Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female is 15 years following a total elbow arthroplasty and has pain and limited motion with radiographic evidence of component loosening. She undergoes revision of the humeral component.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning in a lateral decubitus position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a posterior elbow incision is made. The ulnar nerve is identified for protection throughout the dissection. The triceps and extensor mechanism are released from their insertion on the ulna and then displaced in a radial direction. The elbow joint is exposed and scar tissue is excised and contractures released from the humerus for exposure and soft tissue balancing. Extraction instruments are used to remove the loose humeral component. Meticulous preparation and cleansing of the humeral canal, including fibrous membrane and cement removal, is necessary prior to placement of the prosthetic humeral component. A burr and saw along with cutting guides are used to cut the proximal ulna or the distal humerus as necessary. After a trial component is inserted in a correct position, the final component is inserted using cement in order to complete the procedure. Judgment and technical skill are necessary to carefully align the component with the proper degree of rotation. The tourniquet is released, hemostasis obtained, the collateral ligaments repaired and the triceps tendon/extensor mechanism is re-approximated to the proximal ulna. The subcutaneous tissue is approximated and the skin is closed.

Description of Post-Service Work: Hospital - through discharge from recovery room: Apply sterile dressings and splint. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery

room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic elbow. Write orders for progression to active exercise. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples and sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	William Creevy, MD; John Heiner, MD; Daniel Nagle, MD; Anne Miller, MD				
Specialty(s):	orthopaedic surgery; hand surgery				
CPT Code:	24370				
Sample Size:	400	**Resp N:**	26	**Response:** 6.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	10.00
Survey RVW:	19.00	23.55	**27.00**	32.00	45.00
Pre-Service Evaluation Time:			**58.00**		
Pre-Service Positioning Time:			**18.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	120.00	143.00	**175.00**	195.00	240.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	24370	**Recommended Physician Work RVU: 23.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**175.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23220	090	30.21	**RUC Time**

CPT Descriptor Radical resection of tumor, proximal humerus

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44140	090	22.59	**RUC Time**	25,612

CPT Descriptor 1 Colectomy, partial; with anastomosis

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.69	**RUC Time**	12,731

CPT Descriptor 2 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

Other Reference CPT Code	Global	Work RVU	Time Source
	090		**RUC Time**

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 26.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 24370**	**Key Reference CPT Code:** 23220	**Source of Time RUC Time**
Median Pre-Service Time	72.00	72.00	
Median Intra-Service Time	175.00	240.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**470.00**	**602.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.43	4.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.71	4.67
Urgency of medical decision making	3.43	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	4.67
Physical effort required	5.00	4.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.86	4.83
Outcome depends on the skill and judgment of physician	5.00	5.00
Estimated risk of malpractice suit with poor outcome	4.29	4.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.43	4.33
Intra-Service intensity/complexity	5.00	4.67
Post-Service intensity/complexity	4.00	4.17

Additional Rationale and Comments

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

Background

CPT codes **24370**, *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component*, and **24371**, *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component* along with **24370**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component*, and **24371**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral*

AND glenoid component were presented to, and approved by, the CPT Editorial Panel at their October 2011 meeting. The rationale for developing the new codes for total shoulder arthroplasty revision and for total elbow arthroplasty revision was to replace the current coding for these procedures which consisted of billing the total joint implant (23472 and 24363 respectively) with implant removal (23331, 23332, and 24160 respectively) with codes for revision of one or both components. This had been requested of the societies by the Centers for Medicare and Medicaid Services (CMS) through written correspondence.

Subsequent to the October 2011 CPT Editorial Panel meeting the new revision codes were forwarded for survey and CMS also asked the societies to survey codes within the respective families. The societies undertook survey efforts for presentation and review at the January 2012 RUC meeting but had collected an insufficient number of surveys for an accurate valuation and at the January 2012 RUC meeting we requested additional time to continue to collect survey responses which was granted and we were able to collect enough additional surveys to provide accurate work RVU recommendations.

The AAOS and ASSH conducted a RUC survey and received 26 responses from surgeons without a financial conflict. The median preservice survey times were 58 minutes for pre-service evaluation time, 15 minutes for pre-service positioning time, and 15 minutes scrub, dress and wait. The survey intra-service time was 175 minutes, and immediate post-service time was 20 minutes. The survey respondents overwhelmingly indicated the procedure is performed in inpatient hospital settings and indicated the typical patient stays three days in the facility with one 99232, two 99231, plus a full hospital facility discharge (99238). The survey results indicated there are typically four post-operative office visits, three 99213 and one 99212.

Survey Sample Description
The survey sample for the surveys was derived randomly. The AAOS pulled a random set of 200 orthopaedic surgeons from their member database and then sent all three surveys to this set of 200. The ASSH sent an email to their entire membership asking for members familiar with the procedures and then forwarded the three surveys to any members who indicated experience with the procedures. The ASES sent all three surveys to a random subset of 200 members.

Recommended wRVU and Physician Times

We are recommending a wRVU of 23.55 which is the survey 25th percentile wRVU. We are recommending the pre-service package 4, difficult patient/diffuclt procedure with 40 minutes pre-service evaluation time, 12 minutes pre-service positioning time (9 minutes more than the package and crosswalked from recently valued elbow codes with the patient positioned lateral decubitis) and 15 minutes pre-service scrub, dress and wait time. We are recommending the survey median intra-service time of 175 minutes and immediate post-service time of 20 minutes. We are recommending the survey post-operative facility visits of 1-99232, 2-99231, and 1-99238 and the survey post-operative office visits of 3-99213 and 1-99212. Total recommended time is 470 minutes and an IWPUT of 0.081.

We believe this is an appropriate value because it is the survey 25th% wRVU and a reasonable IWPUT. It also fits in rank order within the family of elbow implant and joint replacement and revision codes with a slightly higher wRVU than CPT code 24363, Total Elbow Arthroplasty, and lower than 24371, revision of Total Elbow Athroplasty, both components.

Comparison to Key Reference Service

	CPT	RVW	TOT MIN	Pre-Eval	Pre-Position-ing	Pre-SDW	Intra-Service	Immd Post	# and Level Post Fac	# and Level Fac Discharge	# and Level Post Office
Survey Code	24370	**23.55**	**470**	40	12	20	175	20	1-99232 2-99231	1-99238	3-99213 1-99212
Key Ref Code	23220	**30.21**	**602**	40	12	20	240	30	2-99232 2-99231	1-99238	1-99214 2-99213 1-99212

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24363 and 24160

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

Specialty orthopaedic surgery How often? Rarely

Specialty hand surgery How often? Rarely

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 47 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This procedure was previously billed as 24363 + 24160. We assume the 2010 Medicare total utilization for 24160 includes the majority of elbow implant removals as part of a total elbow arthroplasty revision but that a small number of 24160 would have been for implant removals not as a part of a total elbow arthroplasty.

Specialty orthopaedic surgery Frequency 79 Percentage 168.08 %

Specialty hand surgery Frequency 19 Percentage 40.42 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 24363

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24371 Tracking Number F4 Original Specialty Recommended RVU: **27.50**
Presented Recommended RVU: **27.50**
Global Period: 090 RUC Recommended RVU: **27.50**

CPT Descriptor: Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female is 15 years following a total elbow arthroplasty and has pain and limited motion with radiographic evidence of component loosening. She undergoes revision of both the humeral and ulnar components.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning in a lateral decubitus position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a posterior elbow incision is made. The ulnar nerve is identified for protection throughout the dissection. The triceps and extensor mechanism are released from their insertion on the ulna and then displaced in a radial direction. The elbow joint is exposed and scar tissue is excised and contractures released from the humerus and ulna for exposure and soft tissue balancing. Extraction instruments are used to remove the loose humeral and ulnar components, along with all of the fibrous membrane and cement. The proximal ulna is carefully prepared to accept a properly aligned ulnar component, with or without bone graft. Meticulous preparation and cleansing of the humeral canal, including cement removal, is necessary prior to placement of the prosthetic humeral component. A burr and saw along with cutting guides are used to cut the proximal ulna and the distal humerus as necessary. After trial components are inserted in a correct position, the final components are inserted using cement in order to complete the procedure. Judgment and technical skill are necessary to carefully align the components with the proper degree of rotation. The tourniquet is released, hemostasis obtained, the collateral ligaments repaired and the triceps tendon/extensor mechanism is re-approximated to the proximal ulna. The subcutaneous tissue is approximated and the skin is closed.

Description of Post-Service Work: Hospital - through discharge from recovery room: Apply sterile dressings and splint. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic elbow. Write orders for progression to active exercise. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples and sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	William Creevy, MD; John Heiner, MD; Daniel Nagle, MD; Anne Miller, MD				
Specialty(s):	orthopaedic surgery; hand surgery				
CPT Code:	24371				
Sample Size:	400	**Resp N:**	26	**Response:** 6.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	3.00	10.00
Survey RVW:	20.00	27.50	**30.36**	39.50	50.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	140.00	180.00	**210.00**	240.00	360.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	24371	**Recommended Physician Work RVU: 27.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**210.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23220	090	30.21	**RUC Time**

CPT Descriptor Radical resection of tumor, proximal humerus

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63051	090	25.11	**RUC Time**	781

CPT Descriptor 1 Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44626	090	27.90	**RUC Time**	4,250

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

Other Reference CPT Code	Global	Work RVU	Time Source
	090		**RUC Time**

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 23.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 24371**	**Key Reference CPT Code:** 23220	**Source of Time** **RUC Time**
Median Pre-Service Time	72.00	72.00	
Median Intra-Service Time	210.00	240.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**505.00**	**602.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	4.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.00
Urgency of medical decision making	3.50	3.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	4.60
Physical effort required	5.00	4.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.83	4.80
Outcome depends on the skill and judgment of physician	4.67	4.40
Estimated risk of malpractice suit with poor outcome	4.00	4.40

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.33	4.60
Intra-Service intensity/complexity	5.00	4.60
Post-Service intensity/complexity	3.67	3.60

Additional Rationale and Comments

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

Background

CPT codes **24370**, *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component*, and **24371**, *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component* along with **24370**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component*, and **24371**, *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component* were presented to, and approved by, the CPT Editorial Panel at their October 2011 meeting along with new . The rationale for developing the new codes for total shoulder arthroplasty revision and for total elbow arthroplasty revision was to replace the current coding for these procedures which consisted of billing the total joint implant (23472 and 24363 respectively) with implant removal (23331, 23332, and 24160 respectively) with codes for revision of one or both components. This had been requested of the societies by the Centers for Medicare and Medicaid Services (CMS) through written correspondence.

Subsequent to the October 2011 CPT Editorial Panel meeting the new revision codes were forwarded for survey and CMS also asked the societies to survey codes within the respective families. The societies undertook survey efforts for presentation and review at the January 2012 RUC meeting but had collected an insufficient number of surveys for an accurate valuation and at the January 2012 RUC meeting we requested additional time to continue to collect survey responses which was granted and we were able to collect enough additional surveys to provide accurate work RVU recommendations.

The AAOS and ASSH conducted a RUC survey and received 26 responses from surgeons without a financial conflict. The median preservice survey times were 60 minutes for pre-service evaluation time, 15 minutes for pre-service positioning time, and 15 minutes scrub, dress and wait. The survey intra-service time was 210 minutes, and immediate post-service time was 20 minutes. The survey respondents overwhelmingly indicated the procedure is performed in inpatient hospital settings and indicated the typical patient stays three days in the facility with one 99232, two 99231, plus a full hospital facility discharge (99238). The survey results indicated there are typically four post-operative office visits, three 99213 and one 99212.

Survey Sample Description
The survey sample for the surveys was derived randomly. The AAOS pulled a random set of 200 orthopaedic surgeons from their member database and then sent all three surveys to this set of 200. The ASSH sent an email to their entire membership asking for members familiar with the procedures and then forwarded the three surveys to any members who indicated experience with the procedures. The ASES sent all three surveys to a random subset of 200 members.

Recommended wRVU and Physician Times

We are recommending a wRVU of 27.50 which is the survey 25th percentile wRVU. We are recommending the pre-service package 4, difficult patient/diffuclt procedure with 40 minutes pre-service evaluation time, 12 minutes pre-service positioning time (9 minutes more than the package and crosswalked from recently valued elbow codes with the patient positioned lateral debbitus) and 15 minutes pre-service scrub, dress and wait time. We are recommending the survey median intra-service time of 210 minutes and immediate post-service time of 20 minutes. We are recommending the survey post-operative facility visits of 1-99232, 2-99231, and 1-99238 and the survey post-operative office visits of 3-99213 and 1-99212. Total recommended time is 505 minutes and an IWPUT of 0.086.

We believe this is an appropriate value because it is the survey 25th% wRVU and a reasonable IWPUT. It also fits in rank order within the family of elbow implant and joint replacement and revision codes with a slightly higher wRVU than CPT code 24370, revision of Total Elbow Athroplasty, one component which correlates with the higher intra-service time for 24371 compared to 24370.

Comparison to Key Reference Service

	CPT	RVW	TOT MIN	Pre-Eval	Pre-Position-ing	Pre-SDW	Intra-Service	Immd Post	# and Level Post Fac	# and Level Fac Discharge	# and Level Post Office
Survey Code	24371	**27.50**	**505**	40	12	20	210	20	1-99232 2-99231	1-99238	3-99213 1-99212
Key Ref Code	23220	**30.21**	**602**	40	12	20	240	30	2-99232 2-99231	1-99238	1-99214 2-99213 1-99212

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24363 and 24160

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

Specialty orthopaedic surgery How often? Rarely

Specialty hand surgery How often? Rarely

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This procedure was previously billed as 24363 + 24160. We assume the 2010 Medicare total utilization for 24160 represents the total number of elbow implant removals as part of a total elbow arthroplasty revision.

Specialty orthopaedic surgery Frequency 120 Percentage 120.00 %

Specialty Frequency 28 Percentage 28.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 24363

SS Rec Summary

	A	B	C	E	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Y	Z	AA	AB	AC	AH	AI	AJ	AK	AL
3	**ISSUE:**	**Elbow Arthroplasty and Implant Removal**																												
4	**TAB:**	**5**																												
5						**RVW**					**Total**	**PRE**			**INTRA**					**POST-FACILITY**						**POST-OFFICE**				
6	**SOURCE**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**P-SD**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
7	**REF**	**24150**	Radical resection of tumor, shaft or di	7	**0.071**			**23.46**			**522**	40	12	20			180			30		2	1.0	1.0			1	2	1	
8	**2005**	**24363**	Arthroplasty, elbow; with distal humer		**0.085**			**22.65**			**466**	**50**	**18**	**15**			**150**			**30**		**1**	**2**	**1.0**				**3**	**1**	
9	**SVY**	**24363**	Arthroplasty, elbow; with distal humer	**26**	**0.091**	**18.00**	**22.00**	**22.50**	**27.25**	**40.00**	**448**	**45**	**15**	**15**	**100**	**120**	**140**	**150**	**180**	**30**		**1**	**2**	**1.0**				**3**	**1**	
10	**REC**	**24363**	25th percentile RVW		**0.089**			**22.00**			**445**	**40**	**12**	**20**			**140**			**30**		**1**	**2**	**1.0**				**3**	**1**	
11																														
12	**REF**	**23220**	Radical resection of tumor, proximal h	7	**0.078**			**30.21**			**602**	40	12	20			240			30		2	2.0	1.0			1	2	1	
13	**2005**	**24363**	Arthroplasty, elbow; with distal humer	**@100%**	**0.085**			**22.65**			**466**	**50**	**18**	**15**			**150**			**30**		**1**	**2**	**1.0**				**3**	**1**	
14	**HVD**	**24160**	Implant removal; elbow joint	**+@50%**	**0.049**			**8.00**			**242**	**24**	**0**	**25**			**78**			**21**				**1.0**					**3.5**	
15	***Current Value with 24363 and 24160-51 modifier***							**26.65**																						
16	**SVY**	**24370**	Revision of total elbow arthroplasty, ir	**26**	**0.098**	**19.00**	**23.55**	**27.00**	**32.00**	**45.00**	**489**	**58**	**18**	**15**	**120**	**143**	**175**	**195**	**240**	**20**		**1**	**2**	**1.0**				**3**	**1**	
17	**REC**	**24370**	25th percentile RVW		**0.081**			**23.55**			**470**	**40**	**12**	**20**			**175**			**20**		**1**	**2**	**1.0**				**3**	**1**	
18																														
19	**REF**	**23220**	Radical resection of tumor, proximal h	6	**0.078**			**30.21**			**602**	40	12	20			240			30		2	2.0	1.0			1	2	1	
20	**2005**	**24363**	Arthroplasty, elbow; with distal humer	**@100%**	**0.085**			**22.65**			**466**	**50**	**18**	**15**			**150**			**30**		**1**	**2**	**1.0**				**3**	**1**	
21	**HVD**	**24160**	Implant removal; elbow joint	**+@50%**	**0.049**			**8.00**			**242**	**24**	**0**	**25**			**78**			**21**				**1.0**					**3.5**	
22	***Current Value with 24363 and 24160-51 modifier***							**26.65**																						
23	**SVY**	**24371**	Revision of total elbow arthroplasty, ir	**26**	**0.098**	**20.00**	**27.50**	**30.36**	**39.50**	**50.00**	**523**	**60**	**15**	**15**	**140**	**180**	**210**	**240**	**360**	**20**		**1**	**2**	**1.0**				**3**	**1**	
24	**REC**	**24371**	25th percentile RVW		**0.086**			**27.50**			**505**	**40**	**12**	**20**			**210**			**20**		**1**	**2**	**1.0**				**3**	**1**	

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

CPT Long Descriptor:
24160, Implant removal; elbow joint
24363, Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24370, Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component
24371, Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component

Global Period: 090 Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A consensus expert panel committee was convened and reviewed the procedure under review. The consensus panel compared the current PE details for 24160, 24363 and and determined no changes beyond changes in post-operative service time where the level and/or number of post-operative office visits were warranted. Otherwise, standard 090 facility inputs were used for the existing codes as well as the new codes.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: Consensus committee reviewed current PE details as comparison codes for both the existing and the new codes as these are the most relevant to the existing and new code descriptors.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard pre-service clinical labor activities for 090-day global facility codes

Intra-Service Clinical Labor Activities:

Standard intra-service clinical labor activities for 090-day global facility codes

Post-Service Clinical Labor Activities:

Standard post-service clinical labor activities for 090-day global facility codes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE				REFERENCE							
2				24160 PEAC 2002		24160		24363 PEAC 2002		24363		24370		24371	
3	**Meeting Date: April 2012** **Tab:** **Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Implant removal; elbow joint		Implant removal; elbow joint		Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg,		Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg,		Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar		Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**167**	**N/A**	**167**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**95**	**N/A**	**95**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		**5**		**5**		**5**		**5**		**5**		**5**
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**8**		**8**		**8**		**8**		**8**		**8**
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		**7**		**7**		**7**		**7**		**7**		**7**
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16												
48	99212 27 minutes		27		**3.5**		**3.5**		**1**		**1**		**1**		**1**
49	99213 36 minutes		36						**3**		**3**		**3**		**3**
50	99214 53 minutes		53												
51	99215 63 minutes		63												
52	**Total Office Visit Time**	L037D	RN/LPN/MTA	**0**	**95**	**0**	**95**	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**
54	**End: with last office visit before end of global period**														
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**		**4**		**4**		**4**		**4**
57	pack, post-op incision care (staple)	SA052	pack		**1**				**1**		**1**		**1**		**1**
58	pack, post-op incision care (suture & staple)	SA053	pack				**1**				**0**		**0**		**0**
59	**EQUIPMENT**	**CODE**													
60	table, power	EF031	10		**95**		**95**		**135**		**135**		**135**		**135**
61	light, exam	EQ168	10								**135**		**135**		**135**

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE				REFERENCE							
2				24160 PEAC 2002		24160		24363 PEAC 2002		24363		24370		24371	
3	**Meeting Date: April 2012** **Tab:** **Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Implant removal; elbow joint		Implant removal; elbow joint		Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg,		Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg,		Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar		Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**167**	**N/A**	**167**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**	**N/A**	**207**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**	**N/A**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**	**N/A**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**N/A**	**95**	**N/A**	**95**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**	**N/A**	**135**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		**5**		**5**		**5**		**5**		**5**		**5**
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**8**		**8**		**8**		**8**		**8**		**8**
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		**20**		**20**		**20**		**20**		**20**		**20**
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		**7**		**7**		**7**		**7**		**7**		**7**
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16												
48	99212 27 minutes		27		**3.5**		**3.5**		**1**		**1**		**1**		**1**
49	99213 36 minutes		36						**3**		**3**		**3**		**3**
50	99214 53 minutes		53												
51	99215 63 minutes		63												
52	**Total Office Visit Time**	L037D	RN/LPN/MTA	**0**	**95**	**0**	**95**	**0**	**135**	**0**	**135**	**0**	**135**	**0**	**135**
54	**End: with last office visit before end of global period**														
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**		**4**		**4**		**4**		**4**
57	pack, post-op incision care (staple)	SA052	pack		**1**				**1**						
58	pack, post-op incision care (suture & staple)	SA053	pack				**1**				**1**		**1**		**1**
59	**EQUIPMENT**	**CODE**													
60	table, power	EF031	10		**95**		**95**		**135**		**135**		**135**		**135**
61	light, exam	EQ168	10								**135**		**135**		**135**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74170 Tracking Number Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.40**
Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old woman with hepatitis C and hepatocellular carcinoma post liver resection is being followed by her oncologist. The AFP level is newly elevated. A CT scan of the abdomen without and with contrast is ordered to evaluate for recurrence or metastasis.

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

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

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

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

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

Moderate Sedation

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

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

Description of Pre-Service Work:
• Review the reason for the exam and any pertinent clinical history, including history of contrast allergy, renal insufficiency, or other contraindication to IV contrast
• Review any prior imaging studies
• Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists, including need for, and type of, oral contrast agent

Description of Intra-Service Work:
• Supervise insertion of IV catheter and set-up of mechanical injector
• Supervise acquisition of scout views, prescribe area to be scanned, and supervise acquisition of unenhanced axial CT image data
• Supervise use of mechanical power injector for administration of a rapid bolus of intravenous contrast during scanning and acquisition of axial source image sections in multiple phases of contrast enhancement
• Supervise monitoring for contrast reaction or contrast extravasation during injection
• Review the early, intermediate, and delayed phases of CT image data to assure adequacy of anatomic coverage and assess need for additional sections, additional delayed images, or reconstruction of thin sections in specific locations
• Supervise reconstruction of coronal and/or sagittal 2-D multiplanar reformatted (MPR) images and assess need for oblique or other 2D images
• Typically, hundreds of images are acquired, and this total can increase to almost double when the source images are reviewed with the various requisite window/level settings

• Axial and multiplanar reformatted images are interpreted in early, intermediate, and delayed phases using "soft-tissue windows" to provide detailed evaluation of each of the following organs: lower mediastinum, liver, spleen, gallbladder, adrenal glands, kidneys, visualized portions of the ureters, retroperitoneal soft-tissues, stomach, duodenum, small bowel, visualized portions of the colon, all lymph node chains, major abdominal arterial and venous vasculature, and supporting musculature
• Axial and 2-D reformatted images are interpreted using "bone windows" to assess the skeletal structures, using "liver windows" to assess the liver, and "lung windows" to assess the visualized portions of the lungs
• Compare current findings to previous studies
• Dictate report for the medical record

Description of Post-Service Work:
• Review and sign final report
• Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; David Rosman, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74170				
Sample Size:	960	**Resp N:**	75	**Response:** 7.8 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	100.00	**200.00**	400.00	5000.00
Survey RVW:	1.00	1.85	**2.00**	2.10	3.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**18.00**	20.00	60.00

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

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

Specialty Society Recommended Data

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

CPT Code:	74170	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74178	XXX	2.01	**RUC Time**

CPT Descriptor Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99392	XXX	1.50	**RUC Time**	

CPT Descriptor 1 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 50.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 74170**	**Key Reference CPT Code:** 74178	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	18.00	30.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**28.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.45
Urgency of medical decision making	3.21	3.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.68	3.39
Physical effort required	2.34	2.37
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	2.76
Outcome depends on the skill and judgment of physician	4.13	3.71
Estimated risk of malpractice suit with poor outcome	3.45	3.34

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.37	2.32
Intra-Service intensity/complexity	3.76	3.55
Post-Service intensity/complexity	2.39	2.29

Additional Rationale and Comments

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

The ACR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The recommendation is for the median survey times of 5, 18, and 5 minutes of pre, intra, and post time, respectively. Median survey RVU was 2.0; however, we believe that the median value is too high and are recommending a work value of 1.40, which maintains current value. Our recommended RVU value

falls below 25th percentile survey value.

The existing code, which has not been previously RUC surveyed, has a total time of 27 minutes. Our recommended post service time of 5 minutes is in line with other codes in the family which have been RUC surveyed, including 74176 (*Computed tomography, abdomen and pelvis; without contrast material*) and 74177 (*Computed tomography, abdomen and pelvis; with contrast material(s)*), as well as 72192 (*Computed tomography, pelvis; without contrast material*) and 72193 (*Computed tomography, pelvis; with contrast material(s)*).

The most commonly chosen reference service was 74178, (*Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s and further sections in one or both body regions*). This service is RUC valued with an RVU of 2.01 and pre, intra and post times of 5, 30, and 5 minutes, respectively. Our panel believes this service was chosen based on the similarity in the nature of the service and overlap of the service provided. The identical pre and post service times are expected, and demonstrate the consistency and accuracy of the survey data. The lesser intra-service time reflects the fact that the pelvis is not interpreted in the surveyed code.

The Expert Panel also considered the rank order of this code within the family of CT codes, including 74160, Computed tomography, abdomen; with contrast material(s), with an RVU of 1.27 and 15 minutes of intra service time, and 74150, Computed tomography, abdomen; without contrast material, with an RVU of 1.19 and 12 minutes of intra service time.

Our recommendations also compare favorably to our MPC code, 99392 (*Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years*)), with an RVU value of 1.50 and a total time of 28 minutes.

In summary, our Expert Panel is recommending an RVU of 1.40, with pre/intra/post service times of 5/18/5, respectively, for a total time of 28 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74170

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

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2577960
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 74170 provided nationally in a one-year period is estimated to be 2,577,960.

Specialty Diagnostic Radiology Frequency 1929345 Percentage 74.83 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 859,320 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that CPT code 74170 was billed approximately 859,320 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 643115 Percentage 74.83 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74170

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

SS Rec Summary

ISSUE: CT Abdomen w/wo Contrast

TAB: 34

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	74178	Computed tomography, abdomen and pelvis; without contrast material in	38	0.060			2.01			40	5					30			5
CURRENT	74170	Computed tomography, abdomen; without contrast material, followed by contras		#DIV/0!			1.40			27									
SVY	74170	Computed tomography, abdomen; without contrast material, followed by c	75	0.099	1.00	1.85	2.00	2.10	3.50	28	5			5	15	18	20	60	5
REC	74170	Computed tomography, abdomen; without contrast material, followed by contras		0.065			1.40			28	5					18			5

CPT Code: 74170
Specialty Society('s) ACR

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

CPT Long Descriptor:
74170 - Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

Global Period: XXX Meeting Date: 04/2012

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

The American College of Radiology convened a consensus panel to finalize the practice expense data for CPT code 74170.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Since 74170 is an existing code, we used the PEAC approved data as the basis for the practice expense inputs for code 74170.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent/ Interview patient for contraindications
- Prepare room, equipment, supplies/ Enter patient demographic information into the scanner
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure/ Acquire Images
- Clean room/equipment by physician staff
- Process films, hang films and review study with interpreting MD prior to patient discharge

Post-Service Clinical Labor Activities:

	A	B	C	D	F
1				**REFERENCE CODE**	
2				**74170**	**74170**
3	**Meeting Date: April 2012** **Tab: 34** **Specialty: ACR**	**CMS Code**	**Staff Type**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **PEAC approved Aug 2003**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **April 2012**
4	**LOCATION**			**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	**L046A**	**CT Tech**	**72.0**	**56.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L046A**	**CT Tech**	**7.0**	**4.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L046A**	**CT Tech**	**65.0**	**52.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity - *specify:*				
18	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD*	L046A	CT Tech	**7**	**4**
19	**End: When patient enters office/facility for surgery/procedure**				
20	**SERVICE PERIOD**				
21	**Start: When patient enters office/facility for surgery/procedure:**				
22	Greet patient, provide gowning, ensure appropriate medical records are available	L046A	CT Tech	**3**	**3**
23	Obtain vital signs				
24	Provide pre-service education/obtain consent/ *Interview patient for contraindications*	L046A	CT Tech	**3**	**3**
25	Prepare room, equipment, supplies/ *Enter patient demographic information into the scanner*	L046A	CT Tech	**4**	**4**
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L046A	CT Tech	**5**	**5**
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure/ *Acquire Images*	L046A	CT Tech	**32**	**27**
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff	L046A	CT Tech	**3**	**3**
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Other Clinical Activity - *specify:*				
40	*- Process films, hang films and review study with interpreting MD prior to patient discharge*	L046A	CT Tech	**15**	**7**
41	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	**n/a**
42	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**	**n/a**
43	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**	**n/a**
44	**End: Patient leaves office**				
45	**POST-SERVICE Period**				
46	**Start: Patient leaves office/facility**				
47	Conduct phone calls/call in prescriptions				
48	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**
49	99211 16 minutes		16		
50	99212 27 minutes		27		
51	99213 36 minutes		36		

	A	B	C	D	F
1				REFERENCE CODE	
2				74170	74170
3	**Meeting Date: April 2012** **Tab: 34** **Specialty: ACR**	**CMS Code**	**Staff Type**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **PEAC approved Aug 2003**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **April 2012**
4	**LOCATION**			**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
52	99214 53 minutes		53		
53	99215 63 minutes		63		
54	**Total Office Visit Time**			**0.0**	**0.0**
55	Other Clinical Activity - *specify:*				
56	**End: with last office visit before end of global period**				
57	**MEDICAL SUPPLIES**	**CODE**	**UNIT**		
58	swab-pad, alcohol	SJ053	item	**1**	**1**
59	angiocatheter 14g-24g	SC001	item	**1**	**1**
60	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**	**1**
61	povidone swabsticks (3 pack uou)	SJ043	item	**1**	**1**
62	barium suspension (Polibar)	SH016	ml		**900 ml**
63	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**	**1**
64	iv tubing (extension)	SC019	foot	**1**	**1**
65	film, x-ray, laser print	SK098	item	**14**	**14**
66	x-ray envelope	SK091	item	**1**	**1**
67	gauze, sterile 2in x 2in	SG053	item	**1**	**1**
68	gloves, non-sterile	SB022	pair	**1**	**1**
69	heparin lock	SC012	item	**1**	**1**
70	kit, iv starter	SA019	kit	**1**	**1**
71	needle, 18-27g	SC029	item	**1**	**1**
72	computer media, dvd	SK013	item	**1**	**1**
73	gown, patient	SB026	item	**1**	**1**
74	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	item	**1**	**1**
75	syringe 20ml	SC053	item	**1**	**1**
76	paper, exam table	SB036	foot	**7 ft**	**7 ft**
77	tape, surgical paper 1in (Micropore)	SGO79	in	**6 in**	**6 in**
78					
79					
80	**EQUIPMENT**	**CODE**			
81	room, CT	EL007		**65**	**65 mins**
82	film alternator (motorized film viewbox)	ER029		**15**	**15 mins**
83	film processor, dry, laser	ED024		**15**	**15 mins**
84					

	A	B	C	D	F
1				**REFERENCE CODE**	
2				**74170**	**74170**
3	**Meeting Date: April 2012** **Tab: 34** **Specialty: ACR**	**CMS Code**	**Staff Type**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **PEAC approved Aug 2003**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **April 2012**
4	**LOCATION**			**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	**L046A**	**CT Tech**	**72.0**	**72.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L046A**	**CT Tech**	**7.0**	**7.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L046A**	**CT Tech**	**65.0**	**65.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity - *specify:*				
18	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD*	L046A	CT Tech	**7**	**7**
19	**End: When patient enters office/facility for surgery/procedure**				
20	**SERVICE PERIOD**				
21	**Start: When patient enters office/facility for surgery/procedure:**				
22	Greet patient, provide gowning, ensure appropriate medical records are available	L046A	CT Tech	**3**	**3**
23	Obtain vital signs				
24	Provide pre-service education/obtain consent/ *Interview patient for contraindications*	L046A	CT Tech	**3**	**3**
25	Prepare room, equipment, supplies/ *Enter patient demographic information into the scanner*	L046A	CT Tech	**4**	**4**
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L046A	CT Tech	**5**	**5**
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure/ *Acquire Images*	L046A	CT Tech	**32**	**32**
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff	L046A	CT Tech	**3**	**3**
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Other Clinical Activity - *specify:*				
40	*- Process films, hang films and review study with interpreting MD prior to patient discharge*	L046A	CT Tech	**15**	**15**
41	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	**n/a**
42	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**	**n/a**
43	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**	**n/a**
44	**End: Patient leaves office**				
45	**POST-SERVICE Period**				
46	**Start: Patient leaves office/facility**				
47	Conduct phone calls/call in prescriptions				
48	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**
49	99211 16 minutes		16		
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51	99213 36 minutes		36		

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1				REFERENCE CODE	
2				74170	74170
3	**Meeting Date: April 2012** **Tab: 34** **Specialty: ACR**	**CMS Code**	**Staff Type**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **PEAC approved Aug 2003**	CT, abdomen; without contrast material, followed by contrast material(s) and further sections **April 2012**
4	**LOCATION**			**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
52	99214 53 minutes		53		
53	99215 63 minutes		63		
54	**Total Office Visit Time**			**0.0**	**0.0**
55	Other Clinical Activity - *specify:*				
56	**End: with last office visit before end of global period**				
57	**MEDICAL SUPPLIES**	**CODE**	**UNIT**		
58	swab-pad, alcohol	SJ053	item	**1**	**1**
59	angiocatheter 14g-24g	SC001	item	**1**	**1**
60	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**	**1**
61	povidone swabsticks (3 pack uou)	SJ043	item	**1**	**1**
62	barium suspension (Polibar)	SH016	ml		**900 ml**
63	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**	**1**
64	iv tubing (extension)	SC019	foot	**1**	**1**
65	film, x-ray, laser print	SK098	item	**14**	**14**
66	x-ray envelope	SK091	item	**1**	**1**
67	gauze, sterile 2in x 2in	SG053	item	**1**	**1**
68	gloves, non-sterile	SB022	pair	**1**	**1**
69	heparin lock	SC012	item	**1**	**1**
70	kit, iv starter	SA019	kit	**1**	**1**
71	needle, 18-27g	SC029	item	**1**	**1**
72	computer media, dvd	SK013	item	**1**	**1**
73	gown, patient	SB026	item	**1**	**1**
74	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	item	**1**	**1**
75	syringe 20ml	SC053	item	**1**	**1**
76	paper, exam table	SB036	foot	**7 ft**	**7 ft**
77	tape, surgical paper 1in (Micropore)	SGO79	in	**6 in**	**6 in**
78					
79					
80	**EQUIPMENT**	**CODE**			
81	room, CT	EL007		**65**	**65 mins**
82	film alternator (motorized film viewbox)	ER029		**15**	**15 mins**
83	film processor, dry, laser	ED024		**15**	**15 mins**
84					

AMA/S*pecialty Society RVS Update Committee Summary of Recommendations*
Harvard Valued - Utilization over 100,000

April 2012

Denis-Browne Splint Revision

In February 2012, the CPT Editorial Panel accepted a request from the specialty societies to revise CPT code 29590 *Denis-Browne splint strapping* (work RVU=0.76) to more accurately describe the use of the Denis-Browne bar and to differentiate this service from other currently described services. Upon specialty survey, respondents indicated that the revised 29590 descriptor was problematic in that this code now describes manipulation and cast application. According to the specialty presenters, this service is no longer provided, as the prefabricated appliance is applied without manipulation and without casting. **The RUC recommends that the current value of code be maintained pending CPT Editorial Panel action to delete this code as originally proposed.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
#▲29590	FF1	Strapping; to a Denis-Browne bar (splint) with manipulation and casting (eg, for metatarsus adductus, clubfoot) (Do not report 29590 in conjunction with 29450, 29540, 29580, 97760, 97761 and 97762) (Do not report 29590 for fitting or application of shoes to the Denis-Browne orthosis)	000	0.76 (No Change) Refer to CPT Editorial Panel for Deletion

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April 2, 2012

Barbara Levy, MD
Chair, AMA/Specialty Society RVS Update Committee
American Medical Association
515 North State Street
Chicago, Illinois 60654

Subject: Denis-Browne Splinting Code, 29590

Dear Dr. Levy,

The American Academy of Orthopaedic Surgeons is writing in regards to the surveying of CPT code 29590 which is set for review by the AMA/Multi-Specialty Relative Value Update Committee (RUC) at the April 2012 RUC meeting as agenda tab item number 7. CPT code 29590 was originally identified by the RUC's Relativity Assessment Workgroup as a potentially misvalued code due to a different dominant specialty from the original valuing society. In this, 29590 was a Harvard valued code reviewed by the AAOS but, according to 2010 Medicare utilization data, Podiatry was by far the dominant provider. The American Podiatric Medical Society (APMA) submitted a recommendation the Current Procedural Terminology (CPT) Editorial Panel to delete 29590 but the panel, based on input from advisors and panel members, instead chose to revise the work descriptor.

The revised work descriptor and typical patient vignettes were reviewed and approved at the CPT Editorial Panel's February 2012 meeting and it was determined the revision was not editorial and therefore merited survey and review by the RUC. Thus it was placed on the April 2012 RUC agenda.

The descriptor is as follows-29590, Strapping; to a Denis-Browne bar (splint) with manipulation and casting (eg, for metatarsus adductus, clubfoot). We believe it was incorrect to include manipulation and casting as part of a strapping procedure and that it is impossible to compile a suitable reference service list.

Our consensus expert panel reviewed the revised CPT descriptor and unanimously agreed the approved descriptor is not reflective of the actual work involved in the procedure and also is not amenable to a survey as written and therefore the AAOS did not conduct a survey. We recommend the RUC send the code back to the CPT Editorial Panel for time certain as the October 2012 CPT Editorial Panel meeting to consider further edits to the descriptor and possibly again consider deletion as the volume of the procedure is low and the work can already be described by the use of other CPT codes. If the CPT Editorial Panel wishes to revise the approved descriptor we would recommend the language regarding manipulation and casting be removed.

Given that the February 2012 CPT Editorial Panel meeting was the last meeting to make additions, deletions, or edits to the 2013 CPT code book we recommend that the 2013 CPT code book retain the 2012 descriptor for CPT code 29590 which reads as follows: 29590, Denis-Browne splint strapping. Thank you for your attention to this matter and consideration of our request.

Sincerely,

William Creevy, MD
AAOS RUC Advisor

cc: Sherry Smith

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January/April 2012

Bronchial Valve Procedures

At the October 2011 and February CPT meetings, the CPT Editorial Panel approved four new category I codes to report bronchial valve procedures. These services were previously reported using three category III codes, 0250T, 0251T and 0252T.

31647 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe***

The RUC reviewed the survey responses from 30 pulmnologists for CPT code 31647 and determined that a work RVU of 4.40, the survey median, is appropriate. The RUC also recommends the following physician times: 25 minutes of pre-service time, 60 minutes of intra service time and 30 minutes of post service time. The RUC reviewed 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus* (work RVU=4.30) and determined that 31647 requires more physician work since 2-3 valves per lobe are inserted as opposed to one stent. The RUC also reviewed 32601 *Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy* (work RVU=5.50) and calculated a work RVU of 4.11 if 1-99232 *Hospital visit* (5.50 – 1.39 = 4.11) was removed. However, the RUC agreed that the physician work for 31647 was more intense and should be valued higher. **The RUC recommends a work RVU of 4.40 for CPT code 31647.**

31651 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])***

The RUC reviewed the results of 30 pulmnologists and recommends the survey 25th percentile work RVU of 1.58. The RUC reviewed key reference service 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented* (work RVU=1.58) and determined that these two services require similar physician work and the same amount of time to perform. The RUC also reviewed 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less* (work RVU=1.44) and agreed that this procedure requires less physician work and intensity. The RUC also noted that a work RVU of 1.58 would maintain proper rank order within this family of services. **The RUC recommends a work RVU of 1.58 for CPT code 31651.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

31648 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe***

The RUC reviewed the results of 35 pulmnologists and recommends a work RVU of 4.20. The RUC compared 31648 to key reference service 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU=4.88) and determined that although the surveyed code requires less time, 45 minutes versus 60 minutes of intra service time, it is more intense to remove a valve as described in 31648. Furthermore, the key reference code describes the revision of a stent in which the physician goes in once whereas with the surveyed code, 31648, the physician is working with multiple valves in each lobe. The RUC also compared the surveyed code to 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus* (work RVU=4.30) and noted that these services both require 45 minutes of intra service time with similar intensity. Given these comparisons, the RUC agreed with the specialty that the median survey work RVU of 4.20 is an accurate measure of the physician work and intensity involved in this service. **The RUC recommends a work RVU of 4.20 for CPT code 31648.**

31649 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe***
The RUC reviewed the results of 35 pulmnologists and recommends a work RVU of 2.00. The RUC compared 31649 to 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented* (work RVU=1.58) and noted that although the intra-service times are identical, 30 minutes, the intensity of 31649 is greater. CPT Code 31637 refers to one stent per lobe versus the removal of 2-3 valves per lobe. The RUC also compared 31649 to CPT code 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU=2.00) and noted that these services both require 30 minutes of intra service time and therefore should be similarly valued. Given these comparisons, the RUC agreed with the specialty that the median survey work RVU of 2.00 is an accurate measure of the physician work and intensity involved in this service. **The RUC recommends a work RVU of 2.00 for CPT code 31649.**

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

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
⊙31634 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed (Do not report 31634 in conjunction with 31647, 31651 at the same session)				
●⊙31647	G1	with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	000	4.40
●⊙✚31651	G4	with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s]) (Use 31647B in conjunction 31647)	ZZZ	1.58
●⊙31648	G2	with removal of bronchial valve(s), initial lobe (For removal and insertion of a bronchial valve at the same session, see 31647, 31651, and 31648)	000	4.20
●⊙✚31649	G3	with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure) (Use 31649 in conjunction with 31648)	ZZZ	2.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31647 Tracking Number G1 Original Specialty Recommended RVU: **4.40**
Presented Recommended RVU: **4.40**
Global Period: 000 RUC Recommended RVU: **4.40**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year-old female with a persistent air leak after a surgical resection. Air leak (bronchopleural fistula) has not resolved with chest tube to suction for several days. During the bronchoscopy, the leak is identified in one lobe and bronchial valve(s) is/are inserted.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

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

Description of Pre-Service Work: Hospital inpatient or ASC admission and preprocedural work-up, review of records, communication with other professionals, patient and family. Obtain informed consent. The physician and staff dress in disposable gown, non-sterile gloves, and protective eyewear before the procedure. Don lead apron for fluoroscopic guidance, if used. Preparing and positioning the patient and equipment. The physician examines the patient to verify that the patient can undergo the procedure. The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulation.

Description of Intra-Service Work: After the air leak is localized, a sizing balloon is inflated in the target airway to measure the size of the airway and used to determine the appropriate bronchial valve size for the selected airway. An appropriately-sized bronchial valve is then loaded into a deployment catheter. The bronchoscope is advanced to the target bronchus and the deployment catheter, introduced via the working channel, is positioned in the target airway orifice under direct vision. The valve is then deployed. The catheter is removed from the bronchoscope and correct positioning of the bronchial valve is confirmed. The sizing, loading and insertion steps are repeated for additional valve(s) inserted in appropriate subsegment(s) of a given lobe.

Description of Post-Service Work: The physician examines the patient post-bronchoscopy and pre-discharge from the facility to ascertain that no complications, such as bleeding, mucus plugging, or shortness of breath have occurred. The findings from the bronchoscope are explained to the patient and/or family/friend. The physician again reinforces previous instructions about post-procedure complications. The physician generates a detailed report of the procedure. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Alan Plummer, MD, FCCP, ATS, Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, Alternate, ACCP and ATS and Kevin Kovitz, MD		
Specialty(s):	American College of Chest Physicians and the American Thoracic Society		
CPT Code:	31647		
Sample Size:	85	**Resp N:** 30	**Response:** 35.2 %
Description of Sample:	The specialty socities initially survyed the entire group of physicians performing interventional bronchoscopy, but did not receive a response. In follow-up, the socities used a vendor list to target physicians who have been trained to do the procedure or have the equipment.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**3.00**	5.00	16.00
Survey RVW:	1.50	4.30	**4.40**	4.97	6.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**12.50**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	30.00	45.00	**60.00**	60.00	90.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	31647	**Recommended Physician Work RVU: 4.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31636	000	4.30	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required, initial bronchus

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
31634	000	4.00	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed

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

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 53.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 31647**	**Key Reference CPT Code:** 31636	**Source of Time RUC Time**
Median Pre-Service Time	25.00	45.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	30.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**115.00**	**115.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.87
Urgency of medical decision making	3.79	3.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.73	4.67
Physical effort required	3.93	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.93	4.53
Outcome depends on the skill and judgment of physician	4.73	4.80
Estimated risk of malpractice suit with poor outcome	3.93	4.07

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.93	4.00
Intra-Service intensity/complexity	4.73	4.47
Post-Service intensity/complexity	2.87	2.87

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 3164X1 can be reported with its add-on code 3164X1B for placement of more than the initial lobe during the same session. Values will be determined at the April 2012 RUC meeting.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) +0250T

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

Specialty Pulmonary How often? Rarely

Specialty Thoracic Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 450
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expect that this will be 90% pulmonary and 10% thoracic surgery.

Specialty Pulmonary Frequency 405 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 45 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 225
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. About 50% Medicare and 50% other insurers

Specialty Pulmonary` Frequency 203 Percentage 90.22 %

Specialty Thoracic Surgery Frequency 22 Percentage 9.77 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31636

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31651 Tracking Number G4 Original Specialty Recommended RVU: **1.58**
Presented Recommended RVU: **1.58**
Global Period: ZZZ RUC Recommended RVU: **1.58**

CPT Descriptor: Bronchoscopy, rigid or flexible, with fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])

(Use 31651 in conjunction with 31647)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year-old female with a persistent air leak after a surgical resection. Air leak (bronchopleural fistula) has not resolved with chest tube to suction for several days. Leak has not resolved with bronchial valve(s) insertion into one lobe and a leak has been identified in an additional lobe, and bronchial valve(s) is/are inserted.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Additional lobe(s) determined to also be source of leak. A sizing balloon is inflated in the target airway to measure the size of the airway and used to determine the appropriate bronchial valve size for the selected airway. An appropriately-sized bronchial valve is loaded into a deployment catheter. The bronchoscope is advanced to the target bronchus and the deployment catheter, introduced via the working channel, is positioned in the target airway orifice under direct vision. The valve is then deployed. The catheter is removed from the bronchoscope and correct positioning of the bronchial valve is confirmed. The sizing, loading and insertion steps are repeated for additional valve(s) inserted in appropriate subsegment(s) of a given lobe.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Alan Plummer, MD, ATS, Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, Alternate ACCP and ATS and Kevin Kovitz, MD		
Specialty(s):	American College of Chest Physicians and the American Thoracic Society		
CPT Code:	31651		
Sample Size:	85	**Resp N:** 30	**Response:** 35.2 %
Description of Sample:	The specialty socities initially survyed the entire group of physicians performing interventional bronchoscopy, but did not receive a response. In follow-up, the socities used a vendor list to target physicians who have been trained to do the procedure or have the equipment.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.25	**2.00**	4.50	16.00
Survey RVW:	1.00	1.58	**2.08**	3.38	6.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	22.50	**30.00**	45.00	90.00

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

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

Specialty Society Recommended Data

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

CPT Code:	31651	**Recommended Physician Work RVU: 1.58**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

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

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31637	ZZZ	1.58	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	16,519

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	12,010

CPT Descriptor 2 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
99292	ZZZ	2.25	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

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

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 56.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 31651**	**Key Reference CPT Code:** 31637	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.12	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.65
Urgency of medical decision making	3.75	3.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.35	4.41
Physical effort required	3.59	3.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.53	3.94
Outcome depends on the skill and judgment of physician	4.29	4.47
Estimated risk of malpractice suit with poor outcome	3.53	3.47

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.88	4.00
Post-Service intensity/complexity		

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 31651 would be reported with 31647. RUC values will be determined at the April 2012 RUC meeting.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31899

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

Specialty Pulmonary How often? Rarely

Specialty Thoracic Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 250
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. a bit over half of 31647.

Specialty Pulmonary Frequency 225 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 25 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 125
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Expect about 50% Medicare for this rare procedure.

Specialty Pulmonary Frequency 115 Percentage 83.33 %

Specialty Thoracic Surgery Frequency 10 Percentage 16.66 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31637

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31648 Tracking Number G2 Original Specialty Recommended RVU: **4.20**
Presented Recommended RVU: **4.20**
Global Period: 000 RUC Recommended RVU: **4.20**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe
(Do not report 31648 in conjunction with 31622-31626, 31628-31631, 31634-31636, 31638-31646)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year-old female had endobronchial valve(s) placed in a single lobe for control of a persistent air leak. Removal of the valve(s) is indicated from one lobe.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 69%

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

Description of Pre-Service Work: The physician reviews the hospital admission and preprocedural work-up, reviews all records, communicates with other professionals, patient and/or family. An informed consent is obtained.The physician dons a lead apron (if fluoroscopy is used). The pateint is prepared and positioned. The equipment is activated. The physician examines the patient to verify that the patient can undergo the procedure. The physician verifies the identity of the patient and procedure with the call to order in accord with Joint Commission regulations.

Description of Intra-Service Work: Bronchoscopy is performed to identify the target valve(s) and conditions affecting removal. Removal is accomplished by clearing any obstruction and using the appropriate forceps or other retrieval device introduced via the working channel of the bronchoscope and directed to the target valve. The removal rod on the bronchial valve is grasped using the forceps and the valve is gently pulled until it dislodges from the airway wall. The valve is pulled as close as possible to the end of the bronchoscope. The bronchoscope and valve are carefully withdrawn from the patient, with care taken to navigate the valve within the endotracheal tube or rigid bronchoscope to prevent dislodgment. Intubation is strongly recommended to avoid potential valve dislodgement at the vocal cords or in the posterior oropharyx. Intraoperative fluoroscopy may also be required to facilitate valve removal in some cases.

Description of Post-Service Work: The physician examines the pateint post-endoscopy and pre-discharge from the facility to ascertain that no complications, such as plugging, and shortness of breath have occurred. The findings from the procedure are explained to the patient and/or family, friend. The physician again reinforces previous instructions about post-procedural complications. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2011					
Presenter(s):	Kathrin Nicolacakis, MD, ACCP, Alan Plummer, MD, ATS and Kevin Kovitz, MD, ACCP/ATS					
Specialty(s):	American College of Chest Physicians and the American Thoracic Society					
CPT Code:	31648					
Sample Size:	81	**Resp N:**	35	**Response:** 43.2 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.50	10.00
Survey RVW:	3.50	4.00	**4.20**	4.88	6.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	90.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	31648	**Recommended Physician Work RVU: 4.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31638	000	4.88	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

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

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

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,788

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
31636	000	4.30	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required, initial bronchus

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 42.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 31648**	**Key Reference CPT Code:** 31638	**Source of Time RUC Time**
Median Pre-Service Time	25.00	50.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**100.00**	**140.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.87
Urgency of medical decision making	3.47	3.53
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.47	4.33
Physical effort required	4.00	3.73
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.40	4.20
Outcome depends on the skill and judgment of physician	4.47	4.20
Estimated risk of malpractice suit with poor outcome	4.00	3.87

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.93	3.67
Intra-Service intensity/complexity	3.87	3.60
Post-Service intensity/complexity	3.53	3.27

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. with add-on code 31649

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0251T

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

Specialty Pulmonary How often? Rarely

Specialty Thoracic Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pulmonary Frequency 450 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 50 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Ratio for Pulmonary frequency to Thoracic Surgery frequency is based on that only ~10% of survey respondents were thoracic surgeons.

Specialty Pulmonary Frequency 90 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 10 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31638

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31649 Tracking Number G3 Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **2.00**
Global Period: ZZZ RUC Recommended RVU: **2.00**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)
(Use 31649 in conjunction with 31648 initial removal)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59 year-old male had endobronchial valve(s) placed in more than one lobe for control of a persistent air leak. Removal of the valves from both lobes is indicated. The valve from the first lobe has been removed (reported separately) and now the second valve is removed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 69%

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

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Bronchoscopy is performed to identify the target valve(s) and conditions affecting removal. Removal is accomplished by clearing any obstruction and using the appropriate forceps or other retrieval device introduced via the working channel of the bronchoscope and directed to the target valve. The removal rod on the bronchial valve is grasped using the forceps and the valve is gently pulled until it dislodges from the airway wall. The valve is pulled as close as possible to the end of the bronchoscope. The bronchoscope and valve are carefully withdrawn from the patient, with care taken to navigate the valve within the endotracheal tube or rigid bronchoscope to prevent dislodgment. Intubation is strongly recommended to avoid potential valve dislodgement at the vocal cords or in the posterior oropharyx. Intraoperative fluoroscopy may also be required to facilitate valve removal in some cases. The process is repeated until all target valves are removed.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2011					
Presenter(s):	Kathrin Nicolacakis, MD, ACCP, Alan Plummer, MD, ATS and Kevin Kovitz, MD, ACCP/AIS					
Specialty(s):	American College of Chest Physicians and the American Thoracic Society					
CPT Code:	31649					
Sample Size:	81	**Resp N:**	35	**Response:** 43.2 %		
Sample Type:	Random	**Additional Sample Information:**				
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**1.00**	2.50	8.00
Survey RVW:		1.00	1.44	**2.00**	2.50	3.95
Pre-Service Evaluation Time:				**0.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		7.00	15.00	**30.00**	30.00	240.00

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

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

Specialty Society Recommended Data

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

CPT Code:	31649	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

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

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31637	ZZZ	1.58	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99292	ZZZ	2.25	**RUC Time**	414,266

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43338	ZZZ	2.21	**RUC Time**	2,011

CPT Descriptor 2 Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
31627	ZZZ	2.00	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 37.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 31649**	**Key Reference CPT Code:** 31637	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

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

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.54
Urgency of medical decision making	3.08	3.31
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.38	4.31
Physical effort required	3.62	3.62
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.15	4.00
Outcome depends on the skill and judgment of physician	4.54	4.15
Estimated risk of malpractice suit with poor outcome	3.85	3.69

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.46	3.46
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. With base code 31648

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0252T

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

Specialty Pulmonary How often? Rarely

Specialty Thoracic Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Ratio for Pulmonary frequency to Thoracic Surgery frequency is based on that only ~10% of survey respondents were thoracic surgeons.

Specialty Pulmonary Frequency 450 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 50 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Ratio for Pulmonary frequency to Thoracic Surgery frequency is based on that only ~10% of survey respondents were thoracic surgeons.

Specialty Pulmonary Frequency 90 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 10 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

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

---

Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31637

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Bronchial Valves

TAB: 9

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	31636	Bronchoscopy, rigi		0.065			4.30			115	15	15	15			45			25
CURRENT	0250T	Airway sizing and in		#DIV/0!						0									
SVY	31647	Bronchoscop	30	0.049	1.50	4.30	4.40	4.97	5.00	133	20	12.5	10	30	45	60	60	90	30
REC	31647	Bronchoscop	30	0.049			4.40			129	33	1	5			60			30

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	31637	Bronchoscopy, rigid or flexible, including					1.58			30						30			
CURRENT	0250T	Airway sizing and in		#DIV/0!						0									
SVY	31651	Bronchoscop	30	0.069	1.00	1.58	2.08	3.38	6.00	30						30			
REC	31651	Bronchoscop	30	0.053			1.58			30						30			

SS Rec Summary

SPECIALTY **ACCP & ATS**

ISSUE: Bronchial Valve Procedures

TAB: 6

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged			
31647					MIN	25th	MED	75th	MAX																														
Source	CPT	DESC	Resp	IWPUT						Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57
REF	31637	bronch stent,	13	0.053			1.58			30						30																							
CURRENT	0250T			#DIV/0!						0																													
SVY	31647	BV, airway siz	35	0.050	1.00	1,73	2.25	3.14	7.10	45				15	30	45	60	240																					
REC	31647			0.050			2.25			45						45																							
31648					MIN	25th	MED	75th	MAX																														
Source	CPT	DESC	Resp	IWPUT						Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57
REF	31638	stent revision	15	0.051			4.88			140	50					60			30																			
CURRENT	0251T			#DIV/0!						0																													
SVY	31648	initial lobe, rer	35	0.061	3.50	4.00	4.20	4.88	6.00	110		35		15	30	45	60	90	30																			
REC	31648			0.068			4.20			100	19	1	5			45			30																			
31649					MIN	25th	MED	75th	MAX																														
Source	CPT	DESC	Resp	IWPUT						Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57
REF	31637	bronch stent	13	0.053			1.58			30						30																							
CURRENT	0252T			#DIV/0!						0																													
SVY	31649	removal, each addl lo		0.067	1.00	1.44	2.00	2.50	3.95	30				7	15	30	30	240																					
REC	31649			0.067			2.00			30						30																							

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

CPT Long Descriptor:

⊙•**31647 Bronchoscopy, rigid or flexible, with fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe**

⊙+•**31651 with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s). each additional lobe (List separately in addition to code for primary procedure[s]) (Use 31651 in conjunction with 31647**

Global Period: **31647 000 and 31648 ZZZ** Meeting Date: April 26-29, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The American College of Chest Physicians (ACCP) and the American Thoracic Society (ATS) met via conference call to review this code, including all the clinical labor, medical supplies and overhead equipment necessary to perform the procedure. The panel was made up of 2 private practice pulmonary/critical care physicians, 2 academic based pulmonary/critical care physicians, 2 practice administrators for private practice pulmonary/critical care physicians, one RN consultant who works specifically on Pulmonary and Critical Care Coding issues and a CPA who is a consultant to some 20 pulmonary and critical care practices. Please note that the consensus data from the panel was modified to the changes in the rules, policies and procedures of the RUC's Practice Expense Subcommittee.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: Three bronchial valve codes were presented to the AMA RUC's Jan 2012 meeting. RUC referred the placement code back to CPT (which met the next week and approved two placement codes to parallel the 2 removal codes – as ACCP and ATS originally proposed) AND RUC approved the two removal codes. The 31647 stand alone removal code is an excellent comparison for the pre-service times of clinical staff for the bronchial valve stand alone code. There is no pre-service clinical labor time for the 31651 ZZZ add-on bronchial valve code.

Please describe in detail the clinical activities of your staff:

31647 Pre-Service Clinical Labor Activities:

Facility Only

Complete pre-service diagnostic and referral forms

Coordinate pre-surgery services

Schedule space and equipment in the facility

Follow-up phone calls and prescriptions before the procedure

CPT Code: 31648
Specialty Society('s) ACCP and ATS

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

CPT Long Descriptor:

31648 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe
(Do not report 31648 in conjunction with 31622-31626, 31628-31631, 31634-31636, 31638-31646)

Global Period: 000 Meeting Date: January 2012

31647 and 31649 codes are ZZZ codes and Facility Only; therefore, no practice expense for office staff.

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

ACCP and ATS met via conference call to review this code, including all the clinical labor, medical supplies and overhead equipment necessary to perform the procedure. The panel was made up of 2 private practice pulmonary/critical care physicians, 2 academic based pulmonary/critical care physicians, 2 practice administrators for private practice pulmonary/critical care physicians, one RN consultant who works specifically on Pulmonary and Critical Care Coding issues and a CPA who is a consultant to some 20 pulmonary and critical care practices. Please note that the consensus data from the panel was modified to the changes in the rules, policies and procedures of the RUC's Practice Expense Subcommittee.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Facility Only

Complete pre-service diagnostic and referral forms.

Coordinate pre-surgery services

Provide pre-service education and obtain consent

Follow-up phone calls and prescriptions

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Tab 6 Bronchial Valves REVISED**			**31647**		**31648**		**31649**		**31622**		**31634**	
2	**Meeting Date: January 2012 Meeting Tuscon, AZ**	**CMS**	**Staff**	**Bronchoscopy, rigid or flexible, including**		**Bronchoscopy, rigid or flexible,**		**Bronchoscopy, rigid or flexible,**		**Bronchoscopy, rigid or flexible, including**		**Bronchoscopy, rigid or flexible,**	
3	**American College of Chest Physician (ACCP) and the American Thoracic Society (ATS)**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**				**ZZZ**		**0**		**ZZZ**	**0**	**0**		
5	**TOTAL CLINICAL LABOR TIME**												
6	RN CLINICAL LABOR TIME									47.0	0.0	87.0	
7	RN/RT CLINICAL LABOR TIME						**13.0**			91.0	12.0	72.0	
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**						**13.0**			**15.0**	**15.0**	**16.0**	**15.0**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**									**118.0**	**0.0**		
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	L047C	RN/RT				**3**			**5**	**5**		**5**
13	Coordinate pre-surgery services	L047C	RN/RT				**5**			**3**	**5**		**5**
14	Schedule space and equipment in facility						**3**				**3**		**3**
15	Provide pre-service education/obtain consent	L047C	RN/RT				**0**			**5**	**0**		**0**
16	Follow-up phone calls & prescriptions	L047C	RN/RT				**2**			**2**	**2**		**2**
17	Other Clinical Activity (please specify)												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**												
21	Review charts	L047C	RN/RT							**2**			
22	Greet patient and provide gowning	L047C	RN/RT							**3**			
23	Obtain vital signs	L047C	RN/RT							**5**			
24	Provide pre-service education/obtain consent												
25	Prepare room, equipment, supplies	L047C	RN/RT							**2**			
26	Setup scope (non facility setting only)	L047C	RN/RT							**5**			
27	Prepare and position patient/ monitor patient/ set up IV	L047C	RN/RT							**2**			
28	Sedate/apply anesthesia	L051A	RN							**2**			
29	Power and System Preparation and attaching to bronchoscope	L047C	RN/RT										
30	**Intra-service**												
31	Assist Physician - conscious sedation = physician time	L051A	RN							**25**			
32	Assist Physician in performing procedure	L047C	RN/RT							**17**			
33	**Post-Service**												
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN							**15**			
35	Clean room/equipment by physician staff	L047C	RN/RT							**3**			
36	Clean Scope	L047C	RN/RT							**30**			
37	Clean Surgical Instrument Package												
38	Complete diagnostic forms, lab & X-ray requisitions	L047C	RN/RT							**4**			
39	Review/read X-ray, lab, and pathology reports												
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L047C	RN/RT							**3**			
41	Discharge day management												
42	Other Clinical Activity (please specify)												
43	**End: Patient leaves office**												
44	**MEDICAL SUPPLIES**		**Unit**										
45													
46	suction specimen trap, sterile	SD121	1							**1**		**1**	
47	syringe 10-12 ml	SC051	2							**2**		**2**	
48	syringe, 50-60ml sliptip (1)	SC056	1							**1**		**1**	
49	eye shield, splash protection	SM016	2							**2**		**2**	
50	pack, cleaning and disinfecting, endoscope	SA042	1							**1**		**1**	
51	pack, conscious sedation	SA044	1							**1**		**1**	
52	Pack, minimum multi-specialty visit	SA048	1							**1**		**1**	
53	cup, biopsy-specimen sterile 4 oz	SL036	2							**2**			
54	basin, emesis	SJ010	1							**1**		**1**	
55	denture cup	SJ016	1							**1**		**1**	
56	lidocaine 1%-2% inj (Xylocaine)	SH047	40							**40**		**40**	
57	lidocaine 2% jelly, topical (Xylocaine)	SH048	5							**5**		**5**	
58	Lidocaine 4% soln, topical (Xylocaine)	SH050	20							**20**		**20**	
59	sodium chloride 0.9% inj (10ml uou)	SH066	1							**1**		**1**	
60	Transbronchial needle - cytology (58.05)												
61	Balloon dilator (3 x $250= $750)												
62	Tisseel Fibrin Glue, 1ml	SG094										**4**	
63	B5-2C Double lumen galloon 10mm dia	SD261										**1**	
64	Insufflator - Boston Scientific	SD262										**1**	
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	10 pack							**2**		**2**	
66													
67													
68													
69													
70													
71													
72	**Equipment**												
73	videosystem, endoscopy	ES031								**104**		**74**	
74	fiberscope, flexible, bronchoscope	ES017								**104**		**104**	
75	table, power	EF031								**104**		**74**	
76	ECG, 3-channel (with Sp02)	EQ011								**47**		**147**	
77	IV infusion pump	EQ032								**47**		**147**	
78	suction machine (Gomco)	EQ235								**104**		**74**	
79	pulse oximeter with printer	EQ211											
80	fluoroscopic system, mobile C	ER031										**74**	
81	endoscopic forceps, biopsy	ES006											
82	stretcher	EF018										**147**	

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2	**AMA/Specialty Society RVS Update Committee Recommendations**			**31634**		**31647-initial lobe**		**31651**	
3	**Meeting Date: April 25-29, 2012**	**CMS Code**	**Staff Type**	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), **initial lobe**		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), **each additional lobe**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**16.0**	**15.0**	**0.0**	**13.0**		**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**16.0**	**15.0**	**0.0**	**13.0**		**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**		**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**		**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**		**5**		**0**
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**3**	**5**		**3**		**0**
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA				**3**		**0**
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**5**	**3**		**0**		**0**
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**3**	**2**		**2**		**0**
17	Other Clinical Activity - *specify:*								
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available								
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure								
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff								
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Other Clinical Activity - *specify:*								
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27						
49	99213 36 minutes		36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	pack, minimum multi-specialty visit	SA048	pack						
57	**EQUIPMENT**	**CODE**							

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Bronchial Thermoplasty

In February 2012, the CPT Panel transitioned CPT Category III codes 0276T and 0277T to CPT Category I codes 31660 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe* and 31661 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes.* The RUC noted that bronchial thermoplasty is used for the treatment of severe asthma that has been unresponsive to standard medication therapy. This procedure is performed with three outpatient visits typically scheduled two weeks apart. Each lower lobe is treated separately in the first two visits and reported using 31660 and the two upper lobes are treated together in the final visit and reported using 31661.

31660
The RUC reviewed the survey results of 45 pulmonologists and thoracic surgeons and determined that a work RVU of 4.50, the survey median is appropriate for 31660. There was consensus among the RUC members that the specialty societies overestimated pre-service evaluation time of 33 minutes. The RUC determined that 19 minutes was more appropriate which corresponds to the survey median. The RUC reviewed CPT Code 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus* (work RVU=4.30, intra-service time= 45 minutes) and determined that 31660 is a more intense procedure, requires 5 more minutes intra-service time and should be valued higher. The RUC also reviewed 31541 *Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope* (work RVU=4.52, intra-service time=60 minutes) and agreed that these services should be valued similarly. **The RUC recommends a work RVU of 4.50 for CPT code 31660.**

31661
The RUC reviewed the survey results of 45 pulmonologists and thoracic surgeons and determined that a work RVU of 5.00, the survey median is appropriate for 31661. The RUC noted that this procedure requires 10 more minutes of intra-service time than the single lobe procedure, CPT code 31660, to treat both upper lobes for a total of 60 minutes. There was consensus among the RUC members that the specialty societies overestimated pre-service evaluation time of 33 minutes. The RUC reviewed 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU=4.88) and agreed that although 31638 requires the same amount of intra-service time, 31661 is a more intense procedure and should be valued higher. The RUC also reviewed 31600 *Tracheostomy, planned (separate procedure)* (work RVU=7.17) and determined that 31600 requires more total time and intensity and should be valued higher. The RUC also agreed that a work RVU of 5.00 would maintain proper rank order within this family of services. **The RUC recommends a work RVU of 5.00 for CPT code 31661.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
⦿●31660	AA1	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	000	4.50
⦿●31661	AA2	with bronchial thermoplasty, 2 or more lobes	000	5.00
D⦿0276T		~~Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe~~	XXX	N/A
D⦿0277T		~~with bronchial thermoplasty, 2 or more lobes~~ (0276T, 0277T have been deleted. To report, see 31660, 31661)	XXX	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31660 Tracking Number AA1 Original Specialty Recommended RVU: **4.50**
Presented Recommended RVU: **4.50**
Global Period: 000 RUC Recommended RVU: **4.50**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old woman presents with a history of poorly controlled severe asthma. Bronchial thermoplasty is performed on either lower lobe.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 78%

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

Description of Pre-Service Work: Hospital inpatient or ASC admission and preprocedural work-up, review of records, communication with other professionals, patient and family. Obtain informed consent. The physician and staff dress in disposable gown, non-sterile gloves, and protective eyewear before the procedure. Don lead apron for fluoroscopic guidance, if used. Preparing and positioning the patient and equipment. The physician examines the patient to verify that the patient can undergo the procedure. The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulation.

Description of Intra-Service Work: In this procedure, the physician uses the energy created from high-frequency radio waves to reduce airway smooth muscle tissue in the bronchial walls of the lung. The physician skilled in bronchoscopy, working with a skilled bronchoscopic assistant, directs the bronchoscope and operates the catheter. Effective treatment with the radiofrequency catheter requires appropriate patient sedation throughout the procedure.

- A standard patient return electrode is affixed to the patient to provide a complete circuit.
- After the attending physician or anesthesiologist administers appropriate sedation, a standard flexible bronchoscope is inserted through the nose or mouth for access to the lung.
- A detailed inspection of the targeted lobe(s) of the lung is performed to plan the application of bronchial thermoplasty; thereby ensuring that the entire length of each and every accessible bronchial tube in the targeted lobe(s) are treated.
- A small radiofrequency catheter with an expandable electrode array is advanced through the accessory channel of a standard bronchoscope and positioned under direct bronchoscopic visualization into the first treatment area of the targeted lobe(s).
- The electrode array is then expanded and held in contact with the bronchial wall for up to 10 seconds while the radio-frequency controller delivers energy to the location.

- The bronchoscope and catheter are repositioned systematically approximately 55 times such that the electrode array is brought into contact with the entire length of each and every accessible bronchial tube in the targeted lobe(s), thereby providing consistent and thorough thermal treatment throughout the targeted lung region.

Description of Post-Service Work: The physician examines the patient post-bronchoscopy and pre-discharge from the facility to ascertain that no complications, such as bleeding, mucus plugging, acute bronchospasm, or shortness of breath have occurred. The findings from the procedure are explained to the patient and/or family/friend. The physician again reinforces previous instructions about post-procedure complications. The physician generates a detailed report of the procedure. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Burt Lesnick MD, ACCP Advisor; Kathrin Nicolacakis, MD,Alternate ACCP Advisor, Alan Plummer, MD, ATS Advisor and Kevin Kovitz, MD		
Specialty(s):	American College of Chest Physicians and the American Thoracic Society		
CPT Code:	31660		
Sample Size:	80	**Resp N:** 45	**Response:** 56.2 %
Description of Sample:	A Panel survey was conducted. The societies initially survyed the entire group pf physicians performing interventional bronchoscopy and did not receive a response. In follow up, the societies obtained a vendor list of those physicians who have received training to do the procedure.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**7.00**	9.00	30.00
Survey RVW:	1.50	4.25	**4.50**	5.50	12.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**12.50**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	0.00	45.00	**50.00**	60.00	90.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	31660	**Recommended Physician Work RVU: 4.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31636	000	4.30	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
31638	000	4.88	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilatation as required)

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 31660**	**Key Reference CPT Code:** 31636	**Source of Time RUC Time**
Median Pre-Service Time	25.00	45.00	
Median Intra-Service Time	50.00	45.00	
Median Immediate Post-service Time	30.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**105.00**	**115.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.53	4.00
Urgency of medical decision making	3.33	3.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.53	4.40
Physical effort required	4.00	3.87
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	3.80
Outcome depends on the skill and judgment of physician	4.27	4.27
Estimated risk of malpractice suit with poor outcome	3.93	3.64

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.40
Intra-Service intensity/complexity	4.60	4.40
Post-Service intensity/complexity	3.47	3.33

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0276T

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

Specialty Pulmonary How often? Sometimes

Specialty Thoracic Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Rationale is taken from the CPT proposal where noted 6,000 BT annually, with 4,000 X1 and 2,000 X2.

Specialty Pulmonary Frequency 3600 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 400 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Expect that severe asthmatics are 5% for Medicare patients

Specialty Pulmonary Frequency 180 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 20 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31636

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31661 Tracking Number AA2 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: 000 RUC Recommended RVU: **5.00**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old woman presents with a history of poorly controlled severe asthma, previously treated with bronchial thermoplasty on the lower lobes. Bronchial thermoplasty will be performed on both upper lobes.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 78%

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

Description of Pre-Service Work: Hospital inpatient or ASC admission and preprocedural work-up, review of records, communication with other professionals, patient and family. Obtain informed consent. The physician and staff dress in disposable gown, non-sterile gloves, and protective eyewear before the procedure. Don lead apron for fluoroscopic guidance, if used. Preparing and positioning the patient and equipment. The physician examines the patient to verify that the patient can undergo the procedure. The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulation.

Description of Intra-Service Work: The procedure is similar to 31660, but is longer in scope, as it involves navigating the tortuous anatomy of the upper airways and covers more geography than either lower lobe. The bronchoscope and catheter are repositioned systematically approximately 75 times such that the electrode array is brought into contact with the entire length of each and every accessible bronchial tube in the targeted lobe(s), thereby providing consistent and thorough thermal treatment throughout the targeted lung region.

Description of Post-Service Work: The physician examines the patient post-bronchoscopy and pre-discharge from the facility to ascertain that no complications, such as bleeding, mucus plugging, acute bronchospasm, or shortness of breath have occurred. The findings from the procedure are explained to the patient and/or family/friend. The physician again reinforces previous instructions about post-procedure complications. The physician generates a detailed report of the procedure. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Burt Lesnick MD, ACCP Advisor; Kathrin Nicolacakis, MD,Alternate ACCP Advisor, Alan Plummer, MD, ATS Advisor and Kevin Kovitz, MD		
Specialty(s):	American College of Chest Physicians and the American Thoracic Society		
CPT Code:	31661		
Sample Size:	80	**Resp N:** 45	**Response:** 56.2 %
Description of Sample:	A Panel survey was conducted. The societies initially survyed the entire group pf physicians performing interventional bronchoscopy and did not receive a response. In follow up, the societies obtained a vendor list of those physicians who have received training to do the procedure.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	7.00	20.00
Survey RVW:	1.50	4.50	**5.00**	6.24	12.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**12.50**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	0.00	50.00	**60.00**	80.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	31661	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31638	000	4.88	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
31636	000	4.30	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 26.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 31661**	**Key Reference CPT Code:** 31638	**Source of Time RUC Time**
Median Pre-Service Time	25.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**115.00**	**140.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.92
Urgency of medical decision making	3.42	3.58
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	4.67
Physical effort required	4.25	4.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.17
Outcome depends on the skill and judgment of physician	4.67	4.67
Estimated risk of malpractice suit with poor outcome	3.67	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	3.42
Intra-Service intensity/complexity	4.92	4.83
Post-Service intensity/complexity	3.58	3.75

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT Category III code 0277T

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

Specialty Pulmonary How often? Sometimes

Specialty Thoracic Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The CPT application estimated that a total of 6,000 bronchial thermoplasties performed in one year, with 2,000 of those for X2 .

Specialty Pulmonary Frequency 1800 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 200 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated as 5% for these severe asthmatics

Specialty Pulmonary Frequency 90 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 10 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31638

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Bronchial Thermoplasty

TAB: 8

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	31636	Bronchoscopy, rigi		0.065			4.30			115	15	15	15			45			25
CURRENT	0276T	Bronchoscopy, rigid		#DIV/0!						0									
SVY	31660	Bronchoscop	45	0.060	1.50	4.25	4.50	5.50	12.00	128	20	12.5	15	0	45	50	60	90	30
REC	31660	Bronchoscop	45	0.067			4.50			105	19	1	5			50			30

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	31638	Bronchoscopy, rigid		0.055			4.88			140	20	15	15			60			30
CURRENT	0277T	Bronchoscopy, rigid		#DIV/0!						0									
SVY	31661	Bronchoscop	45	0.058	1.50	4.50	5.00	6.24	12.00	138	20	12.5	15	0	50	60	80	180	30
REC	31661	Bronchoscop	45	0.064			5.00			115	19	1	5			60			30

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

CPT Long Descriptor:

31660 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobe

Global Period: **000** Meeting Date: April 26-29, 2012

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

The American College of Chest Physicians (ACCP) and the American Thoracic Society (ATS) met via conference call to review this code, including all the clinical labor, medical supplies and overhead equipment necessary to perform the procedure. The panel was made up of 2 private practice pulmonary/critical care physicians, 2 academic based pulmonary/critical care physicians, 2 practice administrators for private practice pulmonary/critical care physicians, one RN consultant who works specifically on Pulmonary and Critical Care Coding issues and a CPA who is a consultant to some 20 pulmonary and critical care practices. Please note that the consensus data from the panel was modified to the changes in the rules, policies and procedures of the RUC's Practice Expense Subcommittee.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: Three bronchial valve codes were presented to the AMA RUC's Jan 2012 meeting. RUC referred the placement code back to CPT (which met the next week and approved two placement codes to parallel the 2 removal codes – as ACCP and ATS originally proposed) AND RUC approved the two removal codes. The stand alone removal code, initial lobe is an excellent comparison for the pre-service times of clinical staff for the bronchial valve placement codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Facility Only

Complete pre-service diagnostic and referral forms

Coordinate pre-surgery services

Schedule space and equipment in the facility

Follow-up phone calls and prescriptions before the procedure

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2	**Revised 042512 PE Subcommittee**			**31634**		**31660 - 1 LOBE**		**31661 - 2 or More**	
3	**Meeting Date: April 25-29, 2012** **Tab: 8, Bronchial Thermoplasty** **Specialty: ACCP/ATS**	**CMS Code**	**Staff Type**	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**16.0**	**15.0**	**0.0**	**10.0**	**0.0**	**8.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**16.0**	**15.0**	**0.0**	**10.0**	**0.0**	**8.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**		**5**		**3**
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**3**	**5**		**3**		**3**
14	Schedule space and equipment in facility						**0**		**0**
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**5**	**3**		**0**		**0**
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**3**	**2**		**2**		**2**
17	Other Clinical Activity - *specify:*								
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available								
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure								
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff								
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Other Clinical Activity - *specify:*								
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27						
49	99213 36 minutes		36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	pack, minimum multi-specialty visit	SA048	pack						

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2	**Revised 042512 PE Subcommittee**			**31634**		**31660 - 1 LOBE**		**31661 - 2 or More**	
3	**Meeting Date: April 25-29, 2012** **Tab: 8, Bronchial Thermoplasty** **Specialty: ACCP/ATS**	**CMS Code**	**Staff Type**	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**
57	**EQUIPMENT**	**CODE**							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued-Utilization over 30,000

April 2012

Chest Tube Thoracostomy

In April 2011, CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)* was identified in the Harvard Valued-Utilization over 30,000 screen. Prior to conducting a survey, the specialty societies noted a recent shift in the primary specialty from general and cardiothoracic surgery and pulmonary medicine to radiology. They attributed possible miscoding to the description which included "thoracostomy;" parenthetical examples for diagnoses (abscess, hemothorax, empyema) that may have been the primary focus for selecting the code, and an incorrect diagram in CPT following the code. In February 2012, the CPT Editorial Panel modified the code descriptor and parenthetical notes and deleted the diagram.

The RUC reviewed and discussed compelling evidence and agreed that the requirement was met to justify consideration of a different work RVU. Specifically, the methodology used to reduce the work RVU of 32551 for CY 2007 was flawed. Harvard time was cited by CMS that included post-service hospital and office visits. However, in 1993, these post service visits were removed, the global period was changed from 010 to 000, and the work RVU was reduced to 4.07. In addition, CPT Code 38300 was cited by CMS as a comparable reference. However, this code is an office/outpatient, non-urgent procedure that has a negative IWPUT (-0.039) and therefore not a valid reference. Lastly, CPT Code 38500 was also cited by CMS as a comparable reference and reverse building block methodology was used to subtract post-operative work from this minor, non-urgent10-day global code to calculate a work RVU for 32551 which has a 000-day global period. The intra-service intensity and complexity of these two services are not comparable.

The RUC reviewed the survey results from 89 general and cardiothoracic surgeons and pulmonologists and determined that a work RVU of 3.50 which corresponds to the survey's 25th percentile is appropriate for CPT code 32551. The RUC compared 32551 to key reference CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU=4.17) and determined that although 32551 required less time, the work intensity and complexity were greater, resulting in only slightly less total work. This was supported by the survey complexity and intensity measures showing 32551 equal to or greater than all measures when compared with 32550. The RUC compared 32551 to MPC CPT code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU=3.69) and determined that with 10 more minutes of intra service time, 19103 should be valued higher. The RUC compared 32551 to CPT code 16035 *Escharotomy; initial incision* (work RVU=3.74) which has the same intra-time and similar urgency of physician work. The RUC also compared 32551 to CPT code 57461 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix* (work RVU=3.43) and CPT code 15273 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm*

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wound surface area, or 1% of body area of infants and children (work RVU=3.50) and agreed that these two services require similar total physician work. **The RUC recommends a work RVU of 3.50 for CPT Code 32551.**

Practice Expense:

The RUC recommends that this is a facility procedure without direct practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
⊙▲32551	CC1	Tube thoracostomy, includes connection to drainage system (eg, water seal) ~~(eg, for abscess, hemothorax, empyema)~~, when performed, open (separate procedure) ~~*(Do not report 32551 in conjunction with 19260, 19271, 19272, 32503, 32504)*~~ ~~(If imaging guidance is performed, see 75989)~~	000	3.50

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32551 Tracking Number CC1 Original Specialty Recommended RVU: **3.97**
Presented Recommended RVU: **3.50**
Global Period: 000 RUC Recommended RVU: **3.50**

CPT Descriptor: Tube thoracostomy, includes drainage system (eg, water seal), when performed, open

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old patient presents to the emergency room after a motor vehicle collision. Breath sounds are diminished and a large right hemothorax is diagnosed. Via a thoracostomy (ie, open cutdown incision), a chest tube is inserted.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 78%

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

Description of Pre-Service Work: Review available labratory and imaging studies. Examine patient to verify that he can undergo the procedure. Explain procedure to patient/family. Review risks and complications. Obtain informed consent for procedure and conscious sedation. Verify that all required instruments and supplies are available. Mark operative site. Assist with appropriate positioning to expose and stabilize operative site. Prep and drape site. Scrub and gown. Perform "time out." Administer local anesthetic at the skin incision site. Administer or supervise administration of moderate sedation.

Description of Intra-Service Work: An incision is made over the rib below the interspace of intended tube placement. Blunt dissection is carried out through all layers from the skin down through the subcutaneous tissues with additional administration of local anesthesia. The chest wall muscles are bluntly dissected including the deep intercostal muscles and pleura. The clinician’s finger is inserted down into the pleural cavity, digitally sweeping the thoracic cavity. Any fluid or blood under pressure is evacuated. A large bore thoracostomy tube is inserted into the pleural cavity, directed superiorly and posteriorly. Layered closure of muscle and skin is performed. A drainage system is attached and the tube is fixed to the skin with tape.

Description of Post-Service Work: An occlusive dressing is placed. Post-insertion chest x-ray is ordered to verify catheter position and to verify lung response to re-expansion. Monitor patient during reversal of moderate sedation. Assist team in moving patient to stretcher. Discuss post-procedure care with staff. Write post-procedure orders for care and medication. Write brief procedure note. Dictate complete procedure note. Write orders for transferring to appropriate inpatient care setting and discuss ongoing care with floor nurses. All appropriate medical records are completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Christopher Senkowski, MD FACS; Charles Mabry, MD FACS; Francis Nichols, MD FACS; Kevin Kovitz, MD FCCP FACP		
Specialty(s):	general surgery, thoracic surgery, pulmonology		
CPT Code:	32551		
Sample Size: 521	**Resp N:** 89	**Response:** 17.0 %	
Description of Sample:	521 surveys were sent to randomly selected society members		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	12.00	**25.00**	50.00	275.00
Survey RVW:	2.00	3.50	**4.17**	4.70	7.17
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	50.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32551	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**40.00**	**-10.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**20.00**	**-10.00**
Intra-Service Time:		**20.00**		

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

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32550	000	4.17	**RUC Time**

CPT Descriptor Insertion of indwelling tunneled pleural catheter with cuff

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	108,200

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

Other Reference CPT Code	Global	Work RVU	Time Source
37191	000	4.71	**RUC Time**

CPT Descriptor Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

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

Number of respondents who choose Key Reference Code: 37 **% of respondents:** 41.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 32551**	**Key Reference CPT Code:** 32550	**Source of Time RUC Time**
Median Pre-Service Time	43.00	40.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**83.00**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.84	2.94
Urgency of medical decision making	3.89	2.74
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.11	3.03
Physical effort required	2.89	2.74
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.08	2.77
Outcome depends on the skill and judgment of physician	3.22	3.11
Estimated risk of malpractice suit with poor outcome	2.89	2.68

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.46	3.12
Intra-Service intensity/complexity	3.43	3.12
Post-Service intensity/complexity	2.68	2.68

Additional Rationale and Comments

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

Why is this code being reviewed?

Code 32551 was identified as "Harvard-valued with volume greater than 30,000." CMS requested review of this code as potentially misvalued through the "rolling five year review process." When preparing to conduct a RUC survey, it was noted that there has been a recent shift in the specialty reporting of 32551 from general surgery, cardiothoracic surgery, and pulmonology to radiology, as shown in the table below.

32551	1993	1998	2003	2010
FREQ	59,527	53,606	62,787	63,483
General Surgery	34%	34%	28%	18%
Cardiothoracic Surgery	31%	25%	25%	18%
Pulmonology	15%	17%	21%	13%
Radiology	1%	1%	8%	27%

We believe several factors may have resulted in possible miscoding, causing this shift:

1) While the code descriptor includes the word thoracostomy, the descriptor may not clearly indicate 32551 is meant to be an open procedure.
2) The parenthetical examples for diagnoses (abscess, hemothorax, empyema) may have been the primary focus for selecting the code, instead of the procedure's primary term "thoracostomy."
3) The diagram following the code is incorrect. Use of a trocar is considered extremely dangerous.

A CPT coding change proposal for 32551 was submitted and a revised descriptor was approved as follows:

1) Add the word "open" to clearly indicate the approach
2) Indicate water seal as an *example* of a drainage system (not the only system applicable)
3) Remove the parenthetical that refers to diagnoses, as this will not impact the physician work of performing an open tube thoracostomy
4) Delete the parenthetical referencing imaging guidance, as this would rarely be performed
5) Delete the diagram currently shown in CPT 2012 for 32551

Upon approval of the revised descriptor, the ACS, STS, and ACCP/ATS conducted a RUC survey that was sent to a random sample of society members. ACS drew a random sample of general surgeons and trauma surgeons. STS drew a random sample of general thoracic surgeons. ACCP/ATS drew a random sample of pulmonologists. In each of these three groups, some respondents indicated they also specialized in critical care. All respondents had experience in performing the procedure in the past 12 months. Sixty-seven percent of respondents agreed with the typical patient description. Of those who did not agree, most indicated their typical patient would be older or have a spontaneous pneumothorax.

History of the current work RVU

In 1989, the Harvard study surveyed three separate panels to collect information on 32551. Two panels represented thoracic surgeons and one panel represented emergency medicine. General surgery and pulmonology were not included in the Harvard review of this code. All three panels used the vignette "chest tube insertion for spontaneous pneumothorax." All three panels surveyed the code with a 90-global period. The geometric mean intra-time from the three panels was calculated as 24 minutes (range 19-39). Prior to publication of the first fee schedule, CMS reduced the Harvard survey work estimate and changed the global period to 10-days.

In 1992, the published work RVU for 32551 was 4.66 with a global period of 10 days.

In 1993, through refinement, the global period was changed to 000 and the work RVU was further reduced to 4.07.

In 2005, CMS requested review of 32551 as part of the third 5YR. No specialty indicated a level of interest in the code and the RUC did not submit a recommendation for the code.

In the NPRM (June 2006), CMS states:

> For CPT code 32020 (32551), *Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema)(separate procedure)*, although there was no RUC recommendation provided due to the lack of a level interest for surveying this code, we continue to believe that this service is misvalued. This code was presented to the RUC during the two previous 5-Year Reviews. Based on a lack of compelling evidence, the RUC recommended maintaining the work RVUs, and we accepted this recommendation. However, we believe that since valuation of this CPT code continues to be based on Harvard time data, changes in practice and technology have not been incorporated, leading to an overvaluation of this service.
>
> The Harvard time data for this service includes: pre-service time of 46 minutes, intra-service time of 24 minutes, post-service time of 25 minutes, 9 minutes for ICU time, 15 minutes for hospital days, and 2 minutes for office visits for a total time of 121 minutes.
>
> We believe that CPT code 32020 (32551) is comparable to CPT code 38300, *Drainage of lymph node abscess or lymphadenitis; simple*, or CPT code 38500, *Biopsy or excision of lymph node(s); open, superficial*. Both of these CPT codes were reviewed by the RUC during the second 5-Year Review. The RUC times for CPT code 38500 are: pre-service time of 35 minutes, intra-service time of 30 minutes and post-service time of 15 minutes, for a total time of 80 minutes, (plus) one outpatient visit resulting in a work RVU of 3.74. If the value of the outpatient visit is removed from CPT code 38500, this results in an RVU of 3.29. We believe CPT code 32020 (32551) compares favorably to 38500 and propose a work RVU of 3.29 for CPT code 32020 (32551).

Compelling Evidence

1. The Harvard review of code 32551 did not include the three dominant specialties that provide the service; general surgeons and pulmonologists were not included.
2. The rationale provided by CMS to reduce the work RVU of 32551 for CY 2007 was flawed:
   a. CMS cited Harvard time that included post-service hospital and office minutes. However, this time was already stripped from code 32551 when the work RVU was reduced 13% in 1993 and the global period was changed from 010 to 000.
   b. CMS cited code 38300 as a comparable reference. However, code 38300 is an office/outpatient, non-urgent procedure that has a negative IWPUT (-0.039), and therefore is not a valid reference.
   c. CMS cited code 38500 as a comparable reference and used reverse building block to subtract post-op work from this 10-day global code to calculate a work RVU for 32551 which has a 000-global period. CMS incorrectly equated a minor non-urgent procedure (10-day global) with a major urgent 0-day global procedure. The intensity and complexity of these two procedures are not comparable.

Recommendation

Pre-time package 4 is chosen (Difficult Patient/Difficult Procedure) with a reduction in evaluation and scrub, dress, wait times consistent with the urgent nature of the procedure and consistent with the survey median times.

The ACS, STS, and ACCP/ATS recommend a work RVU of 3.97 with the following support:

- This is the work RVU as published in 2006, prior to the CMS reduction that was based on flawed methodology that post-hospital and post-office time were included, even though these minutes and work RVUs were already stripped out by CMS in 1993.
- This work RVU is based on two prior reviews and reductions by CMS (1991 and 1993) that stripped away all hospital visit and office visit time and work.
- This work RVU is supported by the current survey as reviewed by the three dominant specialties.
- This work RVU is also supported by comparison with the key reference code, MPC codes, and several other RUC reviewed 000-global codes requiring similar total physician work.

32551 Changes Over Time

Year	CPT	DESC	Glob	RVW	IWPUT	TOT	PRE	INTRA	POST
MFS 1992	32551	Insert chest tube	**10**	4.66	0.108	121	46	24	51
MFS 1993	32551	Insert chest tube	**0**	4.07	0.107	95	46	24	25
MFS 2006	32551	Insert chest tube	0	3.97	0.103	95	46	24	25
CMS 2007	32551	Insert chest tube	0	3.29	0.075	95	46	24	25
Svy 2012	*32551*	*Insert chest tube*	*0*	*3.97*	*0.135*	*83*	*43*	*20*	*20*

Key Reference Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2004	32550	Insert pleural cath	4.17	0.101	90	40	30	20
2012	*32551*	*Insert chest tube*	*3.97*	*0.135*	*83*	*43*	*20*	*20*

MPC Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2000	19103	Bx breast percut	3.69	0.097	65	20	30	15
2012	*32551*	*Insert chest tube*	*3.97*	*0.135*	*83*	*43*	*20*	*20*
1995	52276	Cystoscopy	4.99	0.104	95	30	35	30

Other Code Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2012	*32551*	*Insert chest tube*	*3.97*	*0.135*	*83*	*43*	*20*	*20*
2005	99291	ICU care	4.50	0.096	70	15	40	15
2011	37191	Insertion IVC filter	4.71	0.120	83	38	30	15
2000	31600	Tracheostomy, planned	7.17	0.114	156	50	40	66

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The Medicare 5% file indicates that 32551 is reported alone 22% of the time, however, there is no single code typically reported with 32551. Patients requiring chest tube placement are typically trauma patients who may undergo other procedures or services on the same date, but at a different time than when the chest tube is placed (eg, diagnostic or operative procedures later in the day).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32551

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

Specialty general surgery How often? Commonly

Specialty thoracic surgery How often? Commonly

Specialty pulmonogy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 53,606 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe that correct reporting for OPEN chest tube placement is less than current reporting. The frequency and percentages shown below correspond to 1998 data - prior to the increased reporting by radiologists. (Please see discussion above under additional rationale.) We believe that education and correct reporting will shift frequency from 32551 to other percutaneous interventions provided by radiologists.

Specialty general surgery Frequency 18227 Percentage 34.00 %

Specialty thoracic surgery Frequency 13405 Percentage 25.00 %

Specialty pulmonology Frequency 9115 Percentage 17.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 19260

SS Rec Summary

ISSUE: Chest Tube Thoracostomy

TAB: 10

						RVW					Total	PRE			INTRA					POST-	SURVEY EXPERIENCE				
SOURCE	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	MIN	25th	MED	75th	MAX
REF	32550	Insertion of indwelling tunneled pleural catheter with cuff	37	0.101			4.17			90	15	10	15			30			20					
MFS 1993	32551	Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)		0.107			4.07			95	14	25	7			24			25					
MFS 2006	32551			0.103			3.97			95	14	25	7			24			25					
MFS 2007-2012	32551			0.075			3.29			95	14	25	7			24			25					
SVY	32551	Tube thoracostomy, includes drainage system (eg, water seal), when performed, open	89	0.137	2.00	3.50	4.17	4.70	7.17	90	30	10	10	5	15	20	30	50	20	2	12	25	50	275
REC		2006 work RVU		0.112			3.50			83	30	3	10			20			20					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization over 30,000

April and October 2012

Chest Tube Interventions

In September 2011, CPT Codes 32420 *Pneumocentesis, puncture of lung for aspiration*, *32421 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent* and 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)* were identified in the Harvard Valued-Utilization over 30,000 screen. At that time, the specialty societies requested, and the RUC agreed that these services should be referred to the CPT Editorial Panel to correctly describe current practice. In February 2012, the CPT Editorial Panel created 32554 *Thoracocentesis, needle or catheter, aspiration of the pleural space; without imaging guidance*, 32555 *Thoracocentesis, needle or catheter, aspiration of the pleural space; with imaging guidance,* 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* and 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter;with imaging guidance* and deleted 32420-32422 to accurately describe these procedures.

The family of codes were initially reviewed by the RUC at the April 2012 meeting. The RUC noted that the specialty societies used a split survey process. Specifically, CPT codes 32554 and 32556 were surveyed primarily by pulmonologists and CPT codes 32555 and 32557 were surveyed by radiologists. The split survey process made it difficult to ascertain the appropriate increment of physician work within this family of services. The RUC recommended that the entire family of codes be resurveyed for the October 2012 RUC meeting. The members recommended that pulmonary medicine resurvey all four codes and radiology resurvey only the imaging codes (32555 & 32557). The RUC recommended interim valuation of for these services based on incorrect utilization assumptions.

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

Practice Expense:
The RUC discussed that the staff type included in practice expense for 32554 and 32556 is more appropriately listed as the RN/LPN/MTA blend rather than RN/RT. A staff type of RT for 32555 and CT Tech for 32557 is appropriate because in past reviews for imaging codes a radiologic or CT technologist has been the accepted clinical staff performing this service. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●32554	DD1	Thoracocentesis, needle or catheter, aspiration of the pleural space; without imaging guidance	000	1.82
●32555	DD2	with imaging guidance	000	2.27
●32556	DD3	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance	000	2.50
●32557	DD4	with imaging guidance (For insertion of indwelling tunneled pleural catheter with cuff, use 32550) (Do not report 32554-32557 in conjunction with 32551, 76942, 77002, 77012, 77021, 75989)	000	3.62
D32420		~~Pneumocentesis, puncture of lung for aspiration~~ (32420 has been deleted. To report, use 32405)	000	N/A
D32421		~~Thoracentesis, puncture of the pleural cavity for aspiration, initial or subsequent~~ ~~(If imaging guidance is performed, see 76942, 77002, 77012)~~	000	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

D32422		~~Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)~~ ~~(Do not report 32422 in conjunction with 19260, 19271, 19272, 32503, 32504)~~ ~~(If imaging guidance is performed, see 76942, 77002, 77012)~~ (32421 and 32422 have been deleted. To report, see 32554, 32555)	000	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32554 Tracking Number DD1 Original Specialty Recommended RVU: **1.83**
Presented Recommended RVU: **1.83**
Global Period: 000 RUC Recommended RVU: **1.54**

CPT Descriptor: Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old male patient presents short of breath with a chest x-ray showing a large left pleural effusion. Bedside aspiration is performed for diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 10%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: Preprocedural work-up, review of records and communication with patient. Obtain informed consent. The physician and staff dress in disposable gown, sterile gloves, and protective eyewear before the procedure. Prepare and position the patient and equipment. The physician examines the patient to verify that the patient can undergo the procedure. The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulation.

Description of Intra-Service Work:
- Chest prepped and draped in sterile fashion.
- 1% subcutaneous Lidocaine solution instilled as local anesthetic
- Needle aspiration of fluid
- Puncture site sterilely dressed
- Fluid sent for appropriate laboratory analysis

Description of Post-Service Work: The physician examines the patient post-thoracentesis to ascertain that no complications have occured. The findings from the procedure are explained to the patient and/or family/friend. The physician again reinforces previous instructions about post-procedure complications. The physician generates a detailed report of the procedure. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Alan Plummer, MD, ATS, Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, Alternate Advisor ACCP and ATS		
Specialty(s):	American College of Chest Physicians (ACCP) and the American Thoracic Society (ATS)		
CPT Code:	32554		
Sample Size:	300	**Resp N:** 31	**Response:** 10.3 %
Description of Sample:	A survey was sent to 300 randomly selected members of ACCP and ATS		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	16.25	**40.00**	50.00	120.00
Survey RVW:	1.20	1.83	**2.30**	2.84	6.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	0.00	15.00	**20.00**	25.00	45.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	32554	**Recommended Physician Work RVU: 1.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**20.00**		

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

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36556	000	2.50	**RUC Time**

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31500	000	2.33	**RUC Time**	274,961

CPT Descriptor 1 Intubation, endotracheal, emergency procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36555	000	2.68	**RUC Time**

CPT Descriptor Insertion of nontunneled centrally inserted central venous catheter, younger than 5

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32554**	**Key Reference CPT Code:** 36556	**Source of Time** **RUC Time**
Median Pre-Service Time	20.00	25.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**50.00**	**50.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.91	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.27
Urgency of medical decision making	3.00	3.36
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.45	3.82
Physical effort required	3.36	3.64
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.55	3.82
Outcome depends on the skill and judgment of physician	4.09	4.18
Estimated risk of malpractice suit with poor outcome	3.55	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.64	2.55
Intra-Service intensity/complexity	3.45	3.36
Post-Service intensity/complexity	2.73	2.91

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32421

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

Specialty Pulmonary How often? Commonly

Specialty Internal Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Rationale based on review of Medicare utilization data for 32421, 32422, and estimating that Medicare is 50%.

Specialty Pulmonary Frequency 100000 Percentage %

Specialty Internal Medicine Frequency 50000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on review of existing codes 32421, 32422.

Specialty Pulmonary Frequency 50000 Percentage %

Specialty Internal Medicine Frequency 25000 Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32421

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32555 Tracking Number DD2 Original Specialty Recommended RVU: **2.40**
Presented Recommended RVU: **2.40**
Global Period: 000 RUC Recommended RVU: **2.21**

CPT Descriptor: Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male patient presents with pneumonia and persistent fever despite antibiotic therapy. Aspiration of his parapneumonic effusion is performed with real-time ultrasound guidance.

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

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

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

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

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

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Description of Pre-Service Work:

- The patient's symptoms, history, and allergies are reviewed.
- Medications are reviewed, specifically potential antiplatelet or anticoagulation agents.
- Lab data is evaluated, particularly coagulation results and platelets.
- Available imaging is reviewed.
- Procedure details are discussed, including pain control and recovery time.
- Alternatives and risks are discussed with the patient and family, and informed consent is reviewed.
- Confirm NPO status.
- Ensure imaging, appropriate specimen containers, and catheter devices are available.
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
- Perform surgical "time out".

Description of Intra-Service Work:

- Preliminary ultrasound is performed of the chest to localize the pleural fluid and target site for drainage. Images are recorded.
- The chest is prepped and draped in the usual sterile fashion.
- The skin and deeper tissues down to the parietal pleura are infiltrated with a local anesthetic under ultrasound guidance, taking care to avoid vessels.
- A thoracentesis catheter is advanced into the pleural effusion under ultrasound guidance and secured in place temporarily.
- Through the catheter a variable amount of fluid is drained.
- The catheter is removed.

- The puncture site is dressed appropriately.
- A sample of fluid is sent to the laboratory for analysis.

Description of Post-Service Work:

- The patient is transferred to the recovery suite and a CXR is obtained (reported separately).
- Post-procedure vital signs are assessed.
- The findings are reviewed with patient and family.
- A report of the procedure is prepared for the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Sean Tutton, M.D., Michael Hall, M.D., Robert L Vogelzang, M.D., and Gerald A. Niedzwiecki, M.D.		
Specialty(s):	ACR and SIR		
CPT Code:	32555		
Sample Size:	1465	**Resp N:** 81	**Response:** 5.5 %
Description of Sample:	The specialty societies performed a random survey of diagnostic radiologists, interventional radiologists and chest physicians, and convened a panel of experts to review the survey data.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	30.00	**60.00**	140.00	500.00
Survey RVW:	1.35	2.00	**2.40**	2.80	5.50
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	3.00	15.00	**20.00**	30.00	45.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	32555	**Recommended Physician Work RVU: 2.21**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**25.00**		

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

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49083	000	2.00	**RUC Time**

CPT Descriptor Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31500	000	2.33	**RUC Time**	274,961

CPT Descriptor 1 Intubation, endotracheal, emergency procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84807

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36556	000	2.50	**RUC Time**

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

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

Number of respondents who choose Key Reference Code: 49 **% of respondents:** 60.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 32555**	**Key Reference CPT Code:** 49083	**Source of Time** **RUC Time**
Median Pre-Service Time	24.00	25.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**54.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.22	2.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.16
Urgency of medical decision making	2.24	2.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.65	2.22
Physical effort required	2.12	1.98
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.67	2.37
Outcome depends on the skill and judgment of physician	2.57	2.29
Estimated risk of malpractice suit with poor outcome	2.22	2.14

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.02	2.16
Intra-Service intensity/complexity	2.45	2.29
Post-Service intensity/complexity	2.20	1.92

Additional Rationale and Comments

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

Background:

CPT codes 32422 (*Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure))* and 32551 (*Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure*)), were identified by the RAW screen for Harvard valued codes with greater than 30,000

utilization. The specialty societies referred these two codes, as well as CPT codes 32420 (*Pneumocentesis, puncture of lung for aspiration*) and 32421 (*Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*), to CPT for revision of the family to better describe current practice. As a result, four new codes were created, two for thoracentesis: non-image guided (32554) and image guided (32555,) and two for pleural catheter placement: non-image guided (32556) and image guided (32557).

Recommendation:
The specialty societies performed a random survey of diagnostic radiologists, interventional radiologists, and chest physicians, and convened a panel of experts to review the survey data. We are recommending the median survey RVU of 2.40 RVUs and the median intra-service time and post-service times of 20 and 10 minutes, respectively.

Pre-Service Period:
The specialty societies recommend pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments: (1) increase the pre-service evaluation time by 2 minutes, and (2) increase the positioning time by 2 minutes, both compatible with our survey results. These adjustments account for the additional time prior to skin prep necessary for ultrasound localization of a suitable pocket of fluid. Based on the survey data, it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work. These modifications to the pre-service times are also compatible with several recently reviewed interventional radiology codes, including paracentesis with imaging guidance (49083).

Key Reference Service:
The most commonly chosen key reference service was 49083 (*Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance*), with 2.00 RVUs and 25 minutes of intra-service time. The second most commonly chosen reference service was 36556 (*Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*), with 2.50 RVUs and 15 minutes of intra-service time. 32555 compares favorably to both of these codes. The intraservice time for 32555 (20 minutes) is lower than 49083 (25 minutes), but the higher RVU is justified by the greater intensity of removing fluid from the pleural space compared to the peritoneal space; This is also supported by 10 of the 11 complexity measures being higher for 32555 than KRS 49083. 32555 is valued lower than 36556 but it has a higher intra-service time so relativity is maintained here also.

Building block methodology:
It should be noted that this is a new CPT code describing a new service with change in dominant provider and service description, so a direct comparison to previously reported codes 32422 and its typical imaging pair, 76942, is not appropriate. As the DOW for the surveyed code suggests, the imaging guidance prior to catheter placement to avoid injury to the lung and pleura, as well as periodic imaging during drainage to ensure optimal drainage of the pleural effusion is distinctly different than in the past, when the procedure was performed based on anatomic landmarks. Drainage is more complete and, as the vignette suggests, performed in a more difficult patient with infection and pleural effusion.

However, as a point of reference for the Panel we provide the following information:
32422 (2.19) + 76942 (0.67) = 2.86

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32421/32422, 76942

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

Specialty Radiology How often? Sometimes

Specialty How often?

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 224,310 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimated frequency for Medicare is 224,310, which is the 2010 Medicare utilization frequency for codes 32421 plus 32422. Based on past frequency data, we estimated the percent performed by Radiology to be about 2.98%.

Specialty Radiology Frequency 6694 Percentage 2.98 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32422

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32556 Tracking Number DD3 Original Specialty Recommended RVU: **2.50**
Presented Recommended RVU: **2.50**
Global Period: 000 RUC Recommended RVU: **2.19**

CPT Descriptor: Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old male patient presents with acute shortness of breath. Chest x-ray shows a right pneumothorax. Bedside chest tube placement is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 67%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

Description of Pre-Service Work: Preprocedural work-up, review of records, communication with patient. Obtain informed consent. The physician and staff dress in disposable gown, sterile gloves, and protective eyewear before the procedure. Prepare and position the patient and equipment. The physician examines the patient to verify that the patient can undergo the procedure. The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulation.

Description of Intra-Service Work:
- Chest prepped and draped in sterile fashion.
- 1% subcutaneous Lidocaine solution instilled as local anesthetic
- Catheter placed through intercostal space
- Catheter secured in place and connected to suction drainage
- Puncture site sterilely dressed

Description of Post-Service Work: The physician examines the patient post-thoracentesis to ascertain that no complications have occured. The findings from the procedure are explained to the patient and/or family/friend. The physician again reinforces previous instructions about post-procedure complications. The physician generates a detailed report of the procedure. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Alan Plummer, MD, FCCP, ATS Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, Alternate Advisory, ACCP and ATS				
Specialty(s):	American College of Chest Physicians (ACCP) and the American Thoracic Society (ATS)				
CPT Code:	32556				
Sample Size:	300	**Resp N:**	30	**Response:** 10.0 %	
Description of Sample:	A survey was sent to 300 randomly selected ACCP and ATS members				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	15.00	**20.00**	30.00	100.00
Survey RVW:	1.30	2.50	**2.78**	4.00	6.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	45.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	32556	**Recommended Physician Work RVU: 2.19**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36556	000	2.50	**RUC Time**

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31500	000	2.33	**RUC Time**	274,961

CPT Descriptor 1 Intubation, endotracheal, emergency procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

Other Reference CPT Code	Global	Work RVU	Time Source
36555	000	2.68	**RUC Time**

CPT Descriptor Insertion of nontunneled centrally inserted central venous catheter, younger than 5

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 32556**	**Key Reference CPT Code:** 36556	**Source of Time**
Median Pre-Service Time	25.00	25.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**50.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.33
Urgency of medical decision making	4.22	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.22	3.78
Physical effort required	3.89	3.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.22	3.67
Outcome depends on the skill and judgment of physician	4.00	3.56
Estimated risk of malpractice suit with poor outcome	3.78	3.89

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.10
Intra-Service intensity/complexity	3.90	3.70
Post-Service intensity/complexity	3.40	3.30

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32422

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

Specialty Pulmonary How often? Commonly

Specialty Internal Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ACCP/ATS believes that ACR listed as the most frequent provider will migrate to the new codes with imaging.

Specialty Pulmonary Frequency 100000 Percentage 50.00 %

Specialty Internal Medicine Frequency 50000 Percentage 25.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Reviewed RUC Database for 32421, 32422

Specialty Pulmonary Frequency 50000 Percentage 50.00 %

Specialty Internal Medicine Frequency 25000 Percentage 25.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32422

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32557 Tracking Number DD4 Original Specialty Recommended RVU: **3.37**
Presented Recommended RVU: **3.37**
Global Period: 000 RUC Recommended RVU: **3.35**

CPT Descriptor: Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male patient presents with fever and shortness of breath. CT scan shows a complex parapneumonic effusion. Concern is for an empyema. Image-guided pleural drainage tube placement is performed.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 78%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 16%

Description of Pre-Service Work:

- The patient's symptoms, history, and allergies are reviewed.
- Medications are reviewed, specifically potential antiplatelet or anticoagulation agents.
- Lab data is evaluated, particularly coagulation results and platelets.
- Available imaging is reviewed.
- Procedure details are discussed, including pain control, and recovery time
- Alternatives and risks are discussed with the patient and family, and informed consent is reviewed.
- Confirm NPO status.
- Ensure imaging, appropriate specimen containers, and catheter devices are available.
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
- Perform surgical "time out".

Description of Intra-Service Work:

- Moderate sedation is administered.
- Preliminary CT is performed of the chest to confirm the presence of a pleural fluid collection (empyema) and target the site for drainage. Images are recorded.
- The chest is prepped and draped in the usual sterile fashion.
- The skin and deeper tissues down to the parietal pleura are infiltrated with a local anesthetic under CT guidance, taking care to avoid vessels.
- A needle is advanced into the pleural collection under CT guidance and a guide wire is then advanced through the needle.

- Tract to the pleural space dilated using a series of fascial dilators.
- A multiside hole drainage catheter is advanced into the pleural collection under CT guidance and secured in place temporarily.
- The catheter is secured in place and connected to suction drainage.
- Post procedure CT images may be obtained (included in procedure code).
- The puncture site is dressed appropriately.
- A sample of fluid is sent to the laboratory for analysis.

Description of Post-Service Work:

- The patient is transferred to the recovery suite and a CXR is obtained (reported separately).
- Post-procedure vital signs are assessed.
- The findings are reviewed with patient and family.
- A report of the procedure is prepared for the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Sean Tutton, M.D., Michael Hall, M.D., Robert L Vogelzang, M.D., and Gerald A. Niedzwiecki, M.D.		
Specialty(s):	ACR and SIR		
CPT Code:	32557		
Sample Size:	1465	**Resp N:** 74	**Response:** 5.0 %
Description of Sample:	The specialty societies performed a random survey of diagnostic radiologists, interventional radiologists and chest physicians, and convened a panel of experts to review the survey data.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	15.00	**25.00**	50.00	250.00
Survey RVW:	1.90	3.37	**3.75**	4.00	7.50
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	7.00	20.00	**28.00**	30.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	32557	**Recommended Physician Work RVU: 3.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**21.00**	**19.00**	**2.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49021	000	3.37	**RUC Time**

CPT Descriptor Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	11,496,707

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
49041	000	3.99	**RUC Time**

CPT Descriptor Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

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

Number of respondents who choose Key Reference Code: 34 **% of respondents:** 45.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 32557**	**Key Reference CPT Code:** 49021	**Source of Time** **RUC Time**
Median Pre-Service Time	29.00	38.00	
Median Intra-Service Time	28.00	60.00	
Median Immediate Post-service Time	15.00	26.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**72.00**	**124.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.85	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.03	3.12
Urgency of medical decision making	3.06	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.29	3.12
Physical effort required	3.00	2.85
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	2.94
Outcome depends on the skill and judgment of physician	3.06	3.24
Estimated risk of malpractice suit with poor outcome	3.03	2.97

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.62	2.85
Intra-Service intensity/complexity	3.15	3.26
Post-Service intensity/complexity	2.82	2.65

Additional Rationale and Comments

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

Background:
CPT codes 32422 (*Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure))* and 32551 (*Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure*)), were identified by the RAW screen for Harvard valued codes with greater than 30,000 utilization. The specialty societies referred these two codes, as well as CPT codes 32420 (*Pneumocentesis, puncture of lung for aspiration*) and 32421 (*Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*), to CPT for revision of the family to better describe current practice. As a result, four new codes were created, two for thoracentesis: non-image guided (32554) and image guided (32555), and two for pleural catheter placement: non-image guided (32556) and image guided (32557).

Recommendation:
The specialty societies performed a random survey of diagnostic radiologists, interventional radiologists, and chest physicians, and convened a panel of experts to review the survey data. We are recommending the 25th percentile survey RVU of 3.37 RVUs and the median intra-service time and post-service times of 28 and 15 minutes, respectively.

Pre-Service Period:
The specialty societies recommend pre-service package 1b (Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)) with the following adjustments: (1) increase the pre-service evaluation time by 2 minutes, and (2) increase the positioning time by 2 minutes, both compatible with our survey results. These adjustments account for the additional time prior to skin prep necessary for ultrasound localization of a suitable pocket of fluid. Based on the survey data, it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work. These modifications to the pre-service times are also compatible with several recently reviewed interventional radiology codes, including paracentesis with imaging guidance (49083 (*Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance*)).

Key Reference Service:
The most commonly chosen key reference service was 49021 (*Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*), with 3.37 RVUs and 60 minutes of intra-service time. The second most commonly chosen reference service was 49041 (*Drainage of subdiaphragmatic or subphrenic abscess; percutaneous),* with 3.99 RVUs and 60 minutes of intra-service time. The expert panel recognizes that the intraservice time for 32557 (29 minutes) is lower than 49021 (60 minutes) but working in the chest is more intense than the abdomen as supported by the greater urgency of decision making, technical skill, physical effort and risk of malpractice indicated by survey respondents.

Building block methodology:
It should be noted that this is a new CPT code describing a new service with change in dominant provider and service description, so a direct comparison to previously reported codes 32551 and its typical imaging pair, 75989, is not appropriate. As the DOW for the surveyed code suggests, the imaging guidance prior to catheter placement to avoid injury to the lung and pleura, as well as periodic imaging during drainage to ensure optimal drainage of the pleural effusion is distinctly different than in the past, when the procedure was performed based on anatomic landmarks. Drainage is more complete and, as the vignette suggests performed in a more difficult patient with infection and pleural effusion.

However, as a point of reference for the Panel, we provide the following information:
32551(3.29) + 75989 (1.19) = 4.48

Comparison to other abscess catheter codes:

The expert panels recommendation compares favorably to the entire family of abscess drainage catheter codes as demonstrated in the below table. To reduce the RVU of 32557 lower than 3.37 alters rank order within the family, a circumstance which is made more significant considering that imaging is now included in 32557.

Code	Descriptor	Work RVW	Pre	Intra	Post	Total time	IWPUT
49021	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous	3.37	38	60	26	124	0.0323

44901	Incision and drainage of appendiceal abscess; percutaneous	3.37	38	60	20	118	0.0345
50021	Drainage of perirenal or renal abscess; percutaneous	3.37	38	68	25	131	0.0288
32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance	3.35	29	28	15	72	0.0877
47011	Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages	3.69	38	60	25	123	0.0380
49061	Drainage of retroperitoneal abscess; percutaneous	3.69	38	60	28	126	0.0369
32201	Pneumonostomy; with percutaneous drainage of abscess or cyst	3.99	38	60	24	122	0.0434
49041	Drainage of subdiaphragmatic or subphrenic abscess; percutaneous	3.99	38	60	30	128	0.0411
48511	External drainage, pseudocyst of pancreas; percutaneous	3.99	40	62	25	127	0.0409

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32551, 75989

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

Specialty Radiology How often? Commonly

Specialty How often?

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 63,483 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimated frequency for Medicare is 63,483, which is the 2010 Medicare utilization frequency for code 32251. Based on past frequency data, we estimated the percent performed by Radiology to be about 1.55%.

Specialty Radiology Frequency 986 Percentage 1.55 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32551

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Chest Tube Interventions

TAB: 11

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49	0.052			2.00			60	15	5	5			25			10
CURRENT	32421	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent		0.039			1.54			48	10					28			10
CURRENT	32422	Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)		0.039			2.19			75	15	15				31			14
CURRENT	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation		0.022			0.67			30						30			
SVY	32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance	81	0.084	1.35	2.00	2.40	2.80	5.50	55	15	5	5	3	15	20	30	45	10
REC	32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance		0.077			2.21			54	15	3	6			20			10

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	49021	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous	34	0.032			3.37			124	38					60			26
CURRENT	32551	Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)		0.075			3.29			95	14	25	7			24			25
CURRENT	75989	Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation		#DIV/0!			1.19			23									
SVY	32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance	74	0.087	1.90	3.37	3.75	4.00	7.50	93	30	10	10	7	20	28	30	60	15
REC	32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance		0.087			3.35			72	21	3	5			28			15

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Chest Tube Interventions 32554, 32556 ACCP/ATS

TAB: 11

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	36556	Insertion of non-tunn		0.112			2.50			55	20	5	5			15			10
CURRENT	32421	Thoracentesis, punc		0.039			1.54			48	10					28			10
SVY	32554	Thoracentesis	31	0.086	1.20	1.83	2.30	2.84	6.00	50	13	1	6	0	15	20	25	45	10
REC	32554	Thoracentesis		0.048			1.54			50	13	1	6			20			10

						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	36556	Insertion of non-tunn		0.112			2.50			55	20	5	5			15			10
CURRENT	32422	Thoracentesis with i		0.039			2.19			75	15	15				31			14
SVY	32556	Pleural draina	30	0.098	1.30	2.50	2.78	4.00	6.00	60	19	1	5	5	15	20	30	45	15
REC	32556	Pleural draina		0.068			2.19			60	19	1	5			20			15

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

CPT Long Descriptor:
32554 Thoracentesis, needle or catheter, aspiration of the pleural space, without imaging guidance
32556 Pleural drainage, percutaneous, with insertion of indwelling catheter, without imaging guidance

Global Period: 000 Meeting Date: April 2012

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

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **These two codes are revised codes 32421, 32422. Code 32421 does not have individual data for pre-service, intra-service and post-service so 32422 was used as the comparison code.** 32421 showed clinical staff as an RN. 32422 showed clinical staff as an RT. Currently, we indicate **RN/RT as clinical staff.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Complete pre-service diagnostic and referral forms**
- **Coordinate pre-surgery services**
- **Provide pre-service education/obtain consent**
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- **Greet patient, provide gowning, ensure appropriate medical records are available**
- **Obtain vital signs**
- **Prepare room, equipment and supplies**
- **Prepare and position patient, monitor patient, set up IV**
- **Assist physician in performing the procedure**
- **Monitor patient following service, check tubes, monitors, drains**
- **Clean room and equipment**
- **Complete diagnostic forms, lab and x-ray requisitions**
- **Check dressings and wound, home care instructions provided, coordinate office visits and prescriptions**

Post-Service Clinical Labor Activities:

- **Conduct phone calls and call-in prescriptions**

CPT Code: 32555 and 32557
Specialty Society('s) ACR and SIR

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

CPT Long Descriptor:
32555 - Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance
32557 - Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance

Global Period: 000 Meeting Date: 04/2012

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

The ACR and SIR convened a consensus panel to review and finalize the practice expense data for codes 32555 and 32557.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The existing codes, 32421, 32422, and 32551, are being replaced by the new chest tube placement codes, 32555 and 32557, and the practice expense inputs for these codes are similar to the practice expense inputs for the new codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions
- Retrieve prior images for comparison

Service Clinical Labor Activities:
- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Acquire Image
- Assist physician in performing procedure
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Complete diagnostic forms, lab & X-ray requisitions
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions
- Process images, complete data sheet, present images and data to the interpreting physician

Post-Service Clinical Labor Activities:
- Conduct phone calls/call in prescriptions

CPT Code: 32555 and 32557
Specialty Society('s) ACR and SIR

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

CPT Long Descriptor:
32555 - Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance
32557 - Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance

Global Period: 000 Meeting Date: 04/2012

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

The ACR and SIR convened a consensus panel to review and finalize the practice expense data for codes 32555 and 32557.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

The existing codes, 32421, 32422, and 32551, are being replaced by the new chest tube placement codes, 32555 and 32557, and the practice expense inputs for these codes are similar to the practice expense inputs for the new codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

- Conduct phone calls/call in prescriptions

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**Tab 11: Revised 4/26/12**																
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**			**000**	**000**			**000**	**000**			**000**	**000**
6	**TOTAL TIME**	**L037D**	**RN/LPN/MTA**	**64.0**	**0.0**	**L041B**	**RT**	**80.0**	**0.0**	**L037D**	**RN/LPN/MTA**	**69.0**	**0.0**	**L046A**	**CT Tech**	**76.0**	
7										**L047C**	**RN/RT**	**3.0**		**L051B**	**RDMS**	**5.0**	
8														**L051A**	**RN**	**15.0**	
9														**L041B**	**RT**	**0.0**	
10														**L037D**	**RN/LPN/M**	**0.0**	
11	**PRE-SERVICE**																
12	**Start: Following visit when decision for surgery or procedure made**																
13	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	0		L041B	RT	0		L037D	RN/LPN/MTA	0		L037D	RN/LPN/MTA	0	
14	Coordinate pre-surgery services	L037D	RN/LPN/MTA	1		L041B	RT	1		L037D	RN/LPN/MTA	1		L037D	RN/LPN/MTA	1	
15	Schedule space and equipment in facility	L037D	RN/LPN/MTA			L041B	RT			L037D	RN/LPN/MTA			L046A	CT Tech		
16	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L046A	CT Tech	5	
17	Follow-up phone calls & prescriptions	L037D	RN/LPN/M	3		L041B	RT	3		L037D	RN/LPN/M	3		L046A	CT Tech	3	
18	Other Clinical Activity (please specify): Retrieve prior images for comparison					L041B	RT	3						L046A	CT Tech	6	
19	**End:When patient enters office/facility for surgery/procedure**																
20	**SERVICE PERIOD**																
21	**Start: When patient enters office/facility for surgery/procedure**																
22	**Pre-service services**																
23	Review charts																
24	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		L041B	RT	3		L047C	RN/RT	3		L046A	CT Tech	3	
25	Obtain vital signs	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L046A	CT Tech	5	
26	Provide pre-service education/obtain consent									L037D	RN/LPN/MTA						
27	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		L041B	RT	4		L037D	RN/LPN/MTA	2		L046A	CT Tech	4	
28	Setup scope (non facility setting only)									L037D	RN/LPN/MTA						
29	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		L041B	RT	3		L037D	RN/LPN/MTA	2		L046A	CT Tech	3	
30	Sedate/apply anesthesia													L051A	RN	0	
31	**Intra-service**																
32	Acquire Image					L041B	RT	5						L051B	RDMS	5	
33	Assist physician in performing procedure	L037D	RN/LPN/MTA	20		L041B	RT	20		L037D	RN/LPN/MTA	20		L046A	CT Tech	30	
34	Assist physician - conscious sedation = physician time													L051A	RN	0	
35	-Assist with fluoroscopy/image acquisition (75%)													L041B	RT	0	
36	-Circulating throughout the procedure (25%)													L037D	RNLPN/MTA	0	
37	**Post-Service**																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
38	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	10		L041B	RT	10		L037D	RN/LPN/MTA	15		L051A	RN	15	
39	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		L041B	RT	3		L037D	RN/LPN/MTA	3		L046A	CT Tech	3	
40	Clean Ultrasound							3									
41	Clean Surgical Instrument Package																
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		L041B	RT	2		L037D	RN/LPN/MTA	2		L046A	CT Tech	3	
43	Review/read X-ray, lab, and pathology reports																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L037D	RNLPN/MTA	5	
45	Discharge day management 99238 --12 minutes 99239 --15 minutes																
46	Other Clinical Activity (please specify)																
47	Process images, complete data sheet, present images and data to the interpreting physician					L041B	RT	2						L046A	CT Tech	2	
48	**End: Patient leaves office**																
49	**POST-SERVICE Period**																
50	**Start: Patient leaves office/facility**																
51	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3		L041B	RT	3		L037D	RN/LPN/MTA	3		L046A	CT Tech	3	
52	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate																
53	*List Number and Level of Office Visits*																
54	99211 16 minutes																
55	99212 27 minutes																
56	99213 36 minutes																
57	99214 53 minutes																
58	99215 63 minutes																
59	Other																
60																	
61	*Total Office Visit Time*															0	0
62	Other Activity (please specify)																
64	**MEDICAL SUPPLIES**	CODE	UNIT			CODE	UNIT			CODE	UNIT			CODE	UNIT		
65	PEAC multispecialty supply package																
66	pack, minimum multi-specialty visit	SA048	pack			SA048	pack	1		SA048	pack			SA048	pack	1	
67	kit, thoracentesis (invoice provided)		kit	1		SA070	tray	1			kit				tray		
68	kit, pleural catheter insertion	SA077	kit			SA077	kit			SA077	kit	1		SA077	kit		
69	tray, shave prep	SA067	tray			SA067	tray	1		SA067	tray			SA067	tray	1	
70	mask, surgical, with face shield	SB034	item			SB034	item	2		SB034	item			SB034	item	2	
71	gloves, sterile	SB024	pair	1		SB024	pair	2		SB024	pair	1		SB024	pair	2	
72	gauze, sterile 4in x 4in	SG055	item			SG055	item			SG055	item			SG055	item		
73	gown, staff, impervious	SB027	item	1		SB027	item			SB027	item	1		SB027	item		
74	needle, 19-25g, butterfly	SC030	item			SC030	item			SC030	item			SC030	item		
75	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		SG056	item			SG056	item	1		SG056	item		
76	gown, patient	SB026	item			SB026	item			SB026	item			SB026	item		
77	drape, non-sterile, sheet 40in x 60in	SB006	item	1		SB006	item			SB006	item	1		SB006	item		
78	gloves, non-sterile	SB022	pair			SB022	pair			SB022	pair			SB022	pair		
79	syringe 5-6ml	SC057	item			SC057	item			SC057	item			SC057	item		
80	paper, exam table	SB036	ft			SB036	ft			SB036	ft			SB036	ft		
81	cover, thermometer probe	SB004	item			SB004	item			SB004	item			SB004	item		
82	swab-pad, alcohol	SJ053	item			SJ053	item			SJ053	item			SJ053	item		
83	disinfectant spray (Transeptic)	SM012	ml			SM012	ml	10		SM012	ml			SM012	ml		
84	x-ray envelope	SK091	item			SK091	item			SK091	item			SK091	item		
85	film, x-ray 14in x 17in	SK034	item			SK034	item	3		SK034	item			SK034	item		
86	film, 8inx10in (ultrasound, MRI)	SK022	item			SK022	item	2		SK022	item			SK022	item		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
87	sanitizing cloth-wipe (patient)	SM021	item			SM021	item	2		SM021	item			SM021	item		
88	pillow case	SB037	item			SB037	item			SB037	item			SB037	item		
89	x-ray developer solution	SK089	oz			SK089	oz	1		SK089	oz			SK089	oz		
90	cover-condom, transducer or ultrasound probe	SB005	item			SB005	item	1		SB005	item			SB005	item		
91	lubricating jelly (Surgilube)	SJ033	oz			SJ033	oz	3		SJ033	oz			SJ033	oz		
92	computer media, dvd	SK013	item			SK013	item			SK013	item			SK013	item	1	
93	paper, exam table	SB036	ft			SB036	ft			SB036	ft			SB036	ft		
94	cap, surgical	SB001	item			SB001	item			SB001	item			SB001	item	2	
95	shoe covers, surgical	SB039	pair			SB039	pair			SB039	pair			SB039	pair	2	
96	drape, sterile, three-quarter sheet	SB014	item			SB014	item			SB014	item			SB014	item	1	
97	drape-towel, sterile 18in x 26in	SB019	item			SB019	item			SB019	item			SB019	item	4	
98	drape, sterile, fenestrated 16in x 29in	SB011	item			SB011	item			SB011	item			SB011	item	1	
99	underpad 2ft x 3ft (Chux)	SB044	item			SB044	item			SB044	item			SB044	item	1	
100	povidone soln (Betadine)	SJ041	ml			SJ041	ml			SJ041	ml			SJ041	ml	60	
101	applicator, sponge-tipped	SG009	item			SG009	item			SG009	item			SG009	item	4	
102	lidocaine 1%-2% inj (Xylocaine)	SH047	ml			SH047	ml			SH047	ml			SH047	ml	10	
103	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item			SC058	item			SC058	item			SC058	item	2	
104	blade, surgical (Bard-Parker)	SF007	item			SF007	item			SF007	item			SF007	item	1	
105	stop cock, 3-way	SC049	item			SC049	item			SC049	item			SC049	item	1	
106	syringe 50-60ml	SC056	item			SC056	item			SC056	item			SC056	item	2	
107	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item			SH069	item			SH069	item			SH069	item	1	
108	cup, sterile, 8 oz	SL157	item			SL157	item			SL157	item			SL157	item	1	
109	cup, sterile, 12-16 oz	SL156	item			SL156	item			SL156	item			SL156	item	1	
110	cup, biopsy-specimen sterile 4oz	SL036	item			SL036	item			SL036	item			SL036	item	1	
111	kit, AccuStick II Introducer System with RO Marker	SA071	kit			SA071	kit			SA071	kit			SA071	kit	1	
112	closed flush system, angiography	SC010	item			SC010	item			SC010	item			SC010	item	1	
113	sodium chloride 0.9% flush syringe	SH065	item			SH065	item			SH065	item			SH065	item	1	
114	guidewire	SD088	item			SD088	item			SD088	item			SD088	item	1	
115	dilator, vessel, angiographic	SD043	item			SD043	item			SD043	item			SD043	item	1	
116	drainage catheter, all purpose	SD161	item			SD161	item			SD161	item			SD161	item	1	
117	catheter percutaneous fastener (Percu-Stay)	SD146	item			SD146	item			SD146	item			SD146	item	1	
118	drainage pouch, nephrostomy-biliary	SD163	item			SD163	item			SD163	item			SD163	item	1	
119	tape, surgical paper 1in (Micropore)	SG079	in			SG079	in			SG079	in			SG079	in	12	
120	pack, moderate sedation	SA044	pack			SA044	pack			SA044	pack			SA044	pack	0	
121	gown, surgical, sterile	SB028	item			SB028	item			SB028	item			SB028	item	1	
122	film, x-ray, laser print	SK098	item			SK098	item			SK098	item			SK098	item	1	
123	tape, surgical occlusive 1 inch (Blenderm)	SG078	in	15		SG078	in			SG078	in	25		SG078	in		
124	**Equipment**																
125	Exam table	EF023		66		EF023				EF023		76		EF023			
126	Ultrasound room	EL015				EL015		33		EL015				EL015			
127	Film Alternator	ED024				ED024		58		ED024				ED024		58	
128	Laser printer	ER029				ER029		58		ER029				ER029		58	
129	CT room	EL007				EL007				EL007				EL007		45	
130	ECG, 3 channel	EL007				EL007				EL007				EL007		0	
131	IV fusion pump	EQ032				EQ032				EQ032				EQ032		0	
132	light, exam	EQ168				EQ168				EQ168				EQ168		60	
133	stretcher chair	EF019				EF019		15		EF019				EF019		15	
134	oxygen system, portable	EQ192				EQ192				EQ192				EQ192			
135	pulse oximeter w-printer	EQ211				EQ211				EQ211				EQ211			

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	**Tab 11: Revised 4/26/12**																		
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32002 (32422)**		**32422**				**76942**				**49061**				**76360 (77012)**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32422**	**CMS STAFF TYPE for 32422**	**Thoracentesis with insertion of tube catheter with or without water seal** **(PEAC Approved - Jan 2004)**		**Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)** **(Current RUC Database)**		**CMS CODE for 76942**	**CMS STAFF TYPE for 76942**	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **(PEAC Approved - Feb 2005)**		**CMS CODE for 49061**	**CMS STAFF TYPE for 49061**	**Drainage of retroperitoneal abscess; percutaneous** **(PEAC Approved - Jan 2004)**		**CMS CODE for 77012**	**CMS STAFF TYPE for 77012**	**Computed tomographic guidance for needle biopsy, radiological supervision and interpretation** **(PEAC Approved Jan 2004)**	
4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**			**XXX**	**XXX**			**000**	**000**			**XXX**	**XXX**
6	**TOTAL TIME**	**L041B**	**RT**	**79.0**	**31.0**	**79.0**	**31.0**	**L051B**	**RDMS**	**61.0**	**0.0**	**L037D**	**RN/LPN/MTA**	**11.0**	**0.0**	**L037D**	**RN/LPN/MTA**	**32.0**	**0.0**
7												**L041B**	**RT**	**55.0**					
8												**L051A**	**RN**	**77.0**					
9																			
10																			
11	**PRE-SERVICE**																		
12	**Start: Following visit when decision for surgery or procedure made**																		
13	Complete pre-service diagnostic & referral forms	L041B	RT	5	5	5	5												
14	Coordinate pre-surgery services	L041B	RT	3	10	3	10												
15	Schedule space and equipment in facility	L041B	RT	0	5		5												
16	Provide pre-service education/obtain consent	L041B	RT	5	5	5	5												
17	Follow-up phone calls & prescriptions	L041B	RT	3	3	3	3												
18	Other Clinical Activity (please specify): Retrieve prior images for comparison							L051B	RDMS	3						L037D	RN/LPN/MTA	6	
19	**End:When patient enters office/facility for surgery/procedure**																		
20	**SERVICE PERIOD**																		
21	**Start: When patient enters office/facility for surgery/procedure**																		
22	**Pre-service services**																		
23	Review charts	L041B	RT	2		2													
24	Greet patient and provide gowning	L041B	RT	3		3													
25	Obtain vital signs	L041B	RT	5		5												0	
26	Provide pre-service education/obtain consent													5 (RN/LPN/MTA)					
27	Prepare room, equipment, supplies	L041B	RT	2		2		L051B	RDMS	2				3 (RT)		L037D	RN/LPN/MTA	1	
28	Setup scope (non facility setting only)																		
29	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	2		2		L051B	RDMS	3				2 (RT)		L037D	RN/LPN/MTA	2	
30	Sedate/apply anesthesia													2 (RN)					
31	**Intra-service**																		
32	Acquire Image																		
33	Assist physician in performing procedure	L041B	RT	21		21		L051B	RDMS	45				48 (RT)		L037D	RN/LPN/MTA	18	
34	Assist physician - conscious sedation = physician time																		
35	-Assist with fluoroscopy/image acquisition (75%)																		
36	-Circulating throughout the procedure (25%)																		
37	**Post-Service**													60 (RN) @80%					

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32002 (32422)**		**32422**				**76942**				**49061**				**76360 (77012)**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32422**	**CMS STAFF TYPE for 32422**	**Thoracentesis with insertion of tube catheter with or without water seal** **(PEAC Approved - Jan 2004)**		**Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)** **(Current RUC Database)**		**CMS CODE for 76942**	**CMS STAFF TYPE for 76942**	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **(PEAC Approved - Feb 2005)**		**CMS CODE for 49061**	**CMS STAFF TYPE for 49061**	**Drainage of retroperitoneal abscess; percutaneous** **(PEAC Approved - Jan 2004)**		**CMS CODE for 77012**	**CMS STAFF TYPE for 77012**	**Computed tomographic guidance for needle biopsy, radiological supervision and interpretation** **(PEAC Approved Jan 2004)**	
4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
38	Monitor pt. following service/check tubes, monitors, drains	L041B	RT	15		15								15 (RN)					
39	Clean room/equipment by physician staff	L041B	RT	3		3		L051B	RDMS	3				2 (RT)		L037D	RN/LPN/MTA	3	
40	Clean Ultrasound																		
41	Clean Surgical Instrument Package																		
42	Complete diagnostic forms, lab & X-ray requisitions	L041B	RT	2		2								3 (RN/LPN/MTA)					
43	Review/read X-ray, lab, and pathology reports																		

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32002 (32422)**		**32422**				**76942**				**49061**				**76360 (77012)**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32422**	**CMS STAFF TYPE for 32422**	**Thoracentesis with insertion of tube catheter with or without water seal** **(PEAC Approved - Jan 2004)**		**Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)** **(Current RUC Database)**		**CMS CODE for 76942**	**CMS STAFF TYPE for 76942**	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **(PEAC Approved - Feb 2005)**		**CMS CODE for 49061**	**CMS STAFF TYPE for 49061**	**Drainage of retroperitoneal abscess; percutaneous** **(PEAC Approved - Jan 2004)**		**CMS CODE for 77012**	**CMS STAFF TYPE for 77012**	**Computed tomographic guidance for needle biopsy, radiological supervision and interpretation** **(PEAC Approved Jan 2004)**	
4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L041B	RT	5		5								3 (RN/LPN/MTA)					
45	Discharge day management 99238 --12 minutes 99239 --15 minutes																		
46	Other Clinical Activity (please specify)																		
47	Process images, complete data sheet, present images and data to the interpreting physician							L051B	RDMS	5						L037D	RN/LPN/MTA	2	
48	**End: Patient leaves office**																		
49	**POST-SERVICE Period**																		
50	**Start: Patient leaves office/facility**																		
51	Conduct phone calls/call in prescriptions	L041B	RT	3	3	3	3												
52	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate																		
53	*List Number and Level of Office Visits*																		
54	99211 16 minutes																		
55	99212 27 minutes																		
56	99213 36 minutes																		
57	99214 53 minutes																		
58	99215 63 minutes																		
59	Other																		
60																			
61	*Total Office Visit Time*			0	0	0	0							0	0				
62	Other Activity (please specify)																		
64	**MEDICAL SUPPLIES**	CODE	UNIT					CODE	UNIT			CODE	UNIT			CODE	UNIT		
65	PEAC multispecialty supply package			1															
66	pack, minimum multi-specialty visit	SA048	pack			1		SA048	pack			SA048	pack			SA048	pack		
67	kit, thoracentesis (invoice provided)	SA070	tray	1		1		SA070	tray			SA070	tray			SA070	tray		
68	kit, pleural catheter insertion	SA077	kit					SA077	kit			SA077	kit			SA077	kit		
69	tray, shave prep	SA067	tray	1		1		SA067	tray			SA067	tray	1		SA067	tray		
70	mask, surgical, with face shield	SB034	item	2		2		SB034	item			SB034	item	2		SB034	item		
71	gloves, sterile	SB024	pair	2		2		SB024	pair			SB024	pair	1		SB024	pair		
72	gauze, sterile 4in x 4in	SG055	item	2		2		SG055	item			SG055	item	6		SG055	item		
73	gown, staff, impervious	SB027	item					SB027	item			SB027	item			SB027	item		
74	needle, 19-25g, butterfly	SC030	item					SC030	item			SC030	item			SC030	item		
75	gauze, sterile 4in x 4in (10 pack uou)	SG056	item					SG056	item			SG056	item			SG056	item		
76	gown, patient	SB026	item					SB026	item			SB026	item			SB026	item		
77	drape, non-sterile, sheet 40in x 60in	SB006	item					SB006	item			SB006	item			SB006	item		
78	gloves, non-sterile	SB022	pair					SB022	pair	1		SB022	pair			SB022	pair		
79	syringe 5-6ml	SC057	item					SC057	item			SC057	item			SC057	item		
80	paper, exam table	SB036	ft					SB036	ft			SB036	ft			SB036	ft		
81	cover, thermometer probe	SB004	item					SB004	item			SB004	item			SB004	item		
82	swab-pad, alcohol	SJ053	item					SJ053	item			SJ053	item			SJ053	item		
83	disinfectant spray (Transeptic)	SM012	ml					SM012	ml	10		SM012	ml			SM012	ml		
84	x-ray envelope	SK091	item					SK091	item	1		SK091	item			SK091	item	1	
85	film, x-ray 14in x 17in	SK034	item					SK034	item	3		SK034	item			SK034	item		
86	film, 8inx10in (ultrasound, MRI)	SK022	item					SK022	item	2		SK022	item			SK022	item		

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32002 (32422)**		**32422**				**76942**				**49061**				**76360 (77012)**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32422**	**CMS STAFF TYPE for 32422**	**Thoracentesis with insertion of tube catheter with or without water seal** **(PEAC Approved - Jan 2004)**		**Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)** **(Current RUC Database)**		**CMS CODE for 76942**	**CMS STAFF TYPE for 76942**	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **(PEAC Approved - Feb 2005)**		**CMS CODE for 49061**	**CMS STAFF TYPE for 49061**	**Drainage of retroperitoneal abscess; percutaneous** **(PEAC Approved - Jan 2004)**		**CMS CODE for 77012**	**CMS STAFF TYPE for 77012**	**Computed tomographic guidance for needle biopsy, radiological supervision and interpretation** **(PEAC Approved Jan 2004)**	
4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
87	sanitizing cloth-wipe (patient)	SM021	item					SM021	item	2		SM021	item			SM021	item		
88	pillow case	SB037	item					SB037	item	1		SB037	item			SB037	item		
89	x-ray developer solution	SK089	oz					SK089	oz	1		SK089	oz			SK089	oz		
90	cover-condom, transducer or ultrasound probe	SB005	item					SB005	item	1		SB005	item			SB005	item		
91	lubricating jelly (Surgilube)	SJ033	oz					SJ033	oz	30		SJ033	oz			SJ033	oz		
92	computer media, dvd	SK013	item					SK013	item			SK013	item			SK013	item	1	
93	paper, exam table	SB036	ft					SB036	ft			SB036	ft			SB036	ft	7 feet	
94	cap, surgical	SB001	item					SB001	item			SB001	item	1		SB001	item		
95	shoe covers, surgical	SB039	pair					SB039	pair			SB039	pair	2		SB039	pair		
96	drape, sterile, three-quarter sheet	SB014	item					SB014	item			SB014	item	1		SB014	item		
97	drape-towel, sterile 18in x 26in	SB019	item					SB019	item			SB019	item	4		SB019	item		
98	drape, sterile, fenestrated 16in x 29in	SB011	item					SB011	item			SB011	item	1		SB011	item		
99	underpad 2ft x 3ft (Chux)	SB044	item					SB044	item			SB044	item	1		SB044	item		
100	povidone soln (Betadine)	SJ041	ml					SJ041	ml			SJ041	ml	60		SJ041	ml		
101	applicator, sponge-tipped	SG009	item					SG009	item			SG009	item	4		SG009	item		
102	lidocaine 1%-2% inj (Xylocaine)	SH047	ml					SH047	ml			SH047	ml	10		SH047	ml		
103	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item					SC058	item			SC058	item	2		SC058	item		
104	blade, surgical (Bard-Parker)	SF007	item					SF007	item			SF007	item	1		SF007	item		
105	stop cock, 3-way	SC049	item					SC049	item			SC049	item	1		SC049	item		
106	syringe 50-60ml	SC056	item					SC056	item			SC056	item	2		SC056	item		
107	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item					SH069	item			SH069	item	1		SH069	item		
108	cup, sterile, 8 oz	SL157	item					SL157	item			SL157	item	1		SL157	item		
109	cup, sterile, 12-16 oz	SL156	item					SL156	item			SL156	item	1		SL156	item		
110	cup, biopsy-specimen sterile 4oz	SL036	item					SL036	item			SL036	item	1		SL036	item		
111	kit, AccuStick II Introducer System with RO Marker	SA071	kit					SA071	kit			SA071	kit	1		SA071	kit		
112	closed flush system, angiography	SC010	item					SC010	item			SC010	item	1		SC010	item		
113	sodium chloride 0.9% flush syringe	SH065	item					SH065	item			SH065	item	1		SH065	item		
114	guidewire	SD088	item					SD088	item			SD088	item	1		SD088	item		
115	dilator, vessel, angiographic	SD043	item					SD043	item			SD043	item	1		SD043	item		
116	drainage catheter, all purpose	SD161	item					SD161	item			SD161	item	1		SD161	item		
117	catheter percutaneous fastener (Percu-Stay)	SD146	item					SD146	item			SD146	item	1		SD146	item		
118	drainage pouch, nephrostomy-biliary	SD163	item					SD163	item			SD163	item	1		SD163	item		
119	tape, surgical paper 1in (Micropore)	SG079	in					SG079	in			SG079	in	12		SG079	in		
120	pack, moderate sedation	SA044	pack					SA044	pack			SA044	pack	1		SA044	pack		
121	gown, surgical, sterile	SB028	item					SB028	item			SB028	item	1		SB028	item		
122	film, x-ray, laser print	SK098	item					SK098	item			SK098	item			SK098	item	1	
123	tape, surgical occlusive 1 inch (Blenderm)	SG078	in					SG078	in			SG078	in			SG078	in		
124	**Equipment**																		
125	Exam table	EF023		1		60		EF023				EF023				EF023			
126	Ultrasound room	EL015						EL015		X		EL015				EL015			
127	Film Alternator	ED024						ED024		58		ED024				ED024		1	
128	Laser printer	ER029						ER029		58		ER029				ER029		1	
129	CT room	EL007						EL007				EL007		60		EL007		22	
130	ECG, 3 channel	EL007						EL007				EL007		X		EL007			
131	IV fusion pump	EQ032						EQ032				EQ032		X		EQ032			
132	light, exam	EQ168						EQ168				EQ168		X		EQ168			
133	stretcher chair	EF019						EF019				EF019		X		EF019			
134	oxygen system, portable	EQ192						EQ192				EQ192		X		EQ192			
135	pulse oximeter w-printer	EQ211						EQ211				EQ211		X		EQ211			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**Tab 11: Revised 4/26/12**																
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**			**000**	**000**			**000**	**000**			**000**	**000**
6	**TOTAL TIME**	**L037D**	**RN/LPN/MTA**	**66.0**	**0.0**	**L041B**	**RT**	**90.0**	**0.0**	**L037D**	**RN/LPN/MTA**	**76.0**	**0.0**	**L046A**	**CT Tech**	**79.0**	
7						**L051B**	**RDMS**	**5.0**				**0.0**		**L051B**	**RDMS**	**5.0**	
8														**L051A**	**RN**	**15.0**	
9														**L041B**	**RT**	**0.0**	
10														**L037D**	**RN/LPN/M**	**0.0**	
11	**PRE-SERVICE**																
12	**Start: Following visit when decision for surgery or procedure made**																
13	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L046A	CT Tech	5	
14	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		L041B	RT	3		L037D	RN/LPN/MTA	3		L046A	CT Tech	3	
15	Schedule space and equipment in facility	L037D	RN/LPN/MTA			L041B	RT			L037D	RN/LPN/MTA			L046A	CT Tech		
16	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L046A	CT Tech	5	
17	Follow-up phone calls & prescriptions	L037D	RN/LPN/M	3		L041B	RT	3		L037D	RN/LPN/M	3		L046A	CT Tech	3	
18	Other Clinical Activity (please specify): Retrieve prior images for comparison					L041B	RT	3						L046A	CT Tech	6	
19	**End:When patient enters office/facility for surgery/procedure**																
20	**SERVICE PERIOD**																
21	**Start: When patient enters office/facility for surgery/procedure**																
22	**Pre-service services**																
23	Review charts																
24	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		L041B	RT	3		L047C	RN/RT	3		L046A	CT Tech	3	
25	Obtain vital signs	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L046A	CT Tech	5	
26	Provide pre-service education/obtain consent									L037D	RN/LPN/MTA						
27	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		L041B	RT	4		L037D	RN/LPN/MTA	2		L046A	CT Tech	4	
28	Setup scope (non facility setting only)									L037D	RN/LPN/MTA						
29	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		L041B	RT	3		L037D	RN/LPN/MTA	2		L046A	CT Tech	3	
30	Sedate/apply anesthesia													L051A	RN	0	
31	**Intra-service**																
32	Acquire Image					L051B	RDMS	5						L051B	RDMS	5	
33	Assist physician in performing procedure	L037D	RN/LPN/MTA	20		L041B	RT	20		L037D	RN/LPN/MTA	20		L046A	CT Tech	28	
34	Assist physician - conscious sedation = physician time													L051A	RN	0	
35	-Assist with fluoroscopy/image acquisition (75%)													L041B	RT	0	
36	-Circulating throughout the procedure (25%)													L037D	RNLPN/MTA	0	
37	**Post-Service**																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
38	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	5		L041B	RT	15		L037D	RN/LPN/MTA	15		L051A	RN	15	
39	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		L041B	RT	3		L037D	RN/LPN/MTA	3		L046A	CT Tech	3	
40	Clean Ultrasound							3									
41	Clean Surgical Instrument Package																
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		L041B	RT	2		L037D	RN/LPN/MTA	2		L046A	CT Tech	3	
43	Review/read X-ray, lab, and pathology reports																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	5		L041B	RT	5		L037D	RN/LPN/MTA	5		L046A	CT Tech	3	
45	Discharge day management 99238 --12 minutes 99239 --15 minutes																
46	Other Clinical Activity (please specify)																
47	Process images, complete data sheet, present images and data to the interpreting physician					L041B	RT	5						L046A	CT Tech	2	
48	**End: Patient leaves office**																
49	**POST-SERVICE Period**																
50	**Start: Patient leaves office/facility**																
51	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3		L041B	RT	3		L037D	RN/LPN/MTA	3		L046A	CT Tech	3	
52	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate																
53	*List Number and Level of Office Visits*																
54	99211 16 minutes																
55	99212 27 minutes																
56	99213 36 minutes																
57	99214 53 minutes																
58	99215 63 minutes																
59	Other																
60																	
61	*Total Office Visit Time*															0	0
62	Other Activity (please specify)																
64	**MEDICAL SUPPLIES**	CODE	UNIT			CODE	UNIT			CODE	UNIT			CODE	UNIT		
65	PEAC multispecialty supply package																
66	pack, minimum multi-specialty visit	SA048	pack			SA048	pack	1		SA048	pack			SA048	pack	1	
67	kit, thoracentesis (invoice provided)		kit	1		SA070	tray	1			kit				tray		
68	kit, pleural catheter insertion	SA077	kit			SA077	kit			SA077	kit	1		SA077	kit		
69	tray, shave prep	SA067	tray			SA067	tray	1		SA067	tray			SA067	tray	1	
70	mask, surgical, with face shield	SB034	item			SB034	item	2		SB034	item			SB034	item	2	
71	gloves, sterile	SB024	pair	1		SB024	pair	2		SB024	pair	1		SB024	pair	2	
72	gauze, sterile 4in x 4in	SG055	item			SG055	item			SG055	item			SG055	item		
73	gown, staff, impervious	SB027	item	1		SB027	item			SB027	item	1		SB027	item		
74	needle, 19-25g, butterfly	SC030	item			SC030	item			SC030	item			SC030	item		
75	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		SG056	item			SG056	item	1		SG056	item		
76	gown, patient	SB026	item			SB026	item			SB026	item			SB026	item		
77	drape, non-sterile, sheet 40in x 60in	SB006	item	1		SB006	item			SB006	item	1		SB006	item		
78	gloves, non-sterile	SB022	pair			SB022	pair			SB022	pair			SB022	pair		
79	syringe 5-6ml	SC057	item			SC057	item			SC057	item			SC057	item		
80	paper, exam table	SB036	ft			SB036	ft			SB036	ft			SB036	ft		
81	cover, thermometer probe	SB004	item			SB004	item			SB004	item			SB004	item		
82	swab-pad, alcohol	SJ053	item			SJ053	item			SJ053	item			SJ053	item		
83	disinfectant spray (Transeptic)	SM012	ml			SM012	ml	10		SM012	ml			SM012	ml		
84	x-ray envelope	SK091	item			SK091	item			SK091	item			SK091	item		
85	film, x-ray 14in x 17in	SK034	item			SK034	item	3		SK034	item			SK034	item		
86	film, 8inx10in (ultrasound, MRI)	SK022	item			SK022	item	2		SK022	item			SK022	item		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32554**				**32555**				**32556**				**32557**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32554**	**CMS STAFF TYPE for 32554**	**Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **(April 2012)**		**CMS CODE for 32555**	**CMS STAFF TYPE for 32555**	**Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **(April 2012)**		**CMS CODE for 32556**	**CMS STAFF TYPE for 32556**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **(April 2012)**		**CMS CODE for 32557**	**CMS STAFF TYPE for 32557**	**Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **(April 2012)**	
4	**LOCATION**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
87	sanitizing cloth-wipe (patient)	SM021	item			SM021	item	2		SM021	item			SM021	item		
88	pillow case	SB037	item			SB037	item			SB037	item			SB037	item		
89	x-ray developer solution	SK089	oz			SK089	oz	1		SK089	oz			SK089	oz		
90	cover-condom, transducer or ultrasound probe	SB005	item			SB005	item	1		SB005	item			SB005	item		
91	lubricating jelly (Surgilube)	SJ033	oz			SJ033	oz	3		SJ033	oz			SJ033	oz		
92	computer media, dvd	SK013	item			SK013	item			SK013	item			SK013	item	1	
93	paper, exam table	SB036	ft			SB036	ft			SB036	ft			SB036	ft		
94	cap, surgical	SB001	item			SB001	item			SB001	item			SB001	item	2	
95	shoe covers, surgical	SB039	pair			SB039	pair			SB039	pair			SB039	pair	2	
96	drape, sterile, three-quarter sheet	SB014	item			SB014	item			SB014	item			SB014	item	1	
97	drape-towel, sterile 18in x 26in	SB019	item			SB019	item			SB019	item			SB019	item	4	
98	drape, sterile, fenestrated 16in x 29in	SB011	item			SB011	item			SB011	item			SB011	item	1	
99	underpad 2ft x 3ft (Chux)	SB044	item			SB044	item			SB044	item			SB044	item	1	
100	povidone soln (Betadine)	SJ041	ml			SJ041	ml			SJ041	ml			SJ041	ml	60	
101	applicator, sponge-tipped	SG009	item			SG009	item			SG009	item			SG009	item	4	
102	lidocaine 1%-2% inj (Xylocaine)	SH047	ml			SH047	ml			SH047	ml			SH047	ml	10	
103	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item			SC058	item			SC058	item			SC058	item	2	
104	blade, surgical (Bard-Parker)	SF007	item			SF007	item			SF007	item			SF007	item	1	
105	stop cock, 3-way	SC049	item			SC049	item			SC049	item			SC049	item	1	
106	syringe 50-60ml	SC056	item			SC056	item			SC056	item			SC056	item	2	
107	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item			SH069	item			SH069	item			SH069	item	1	
108	cup, sterile, 8 oz	SL157	item			SL157	item			SL157	item			SL157	item	1	
109	cup, sterile, 12-16 oz	SL156	item			SL156	item			SL156	item			SL156	item	1	
110	cup, biopsy-specimen sterile 4oz	SL036	item			SL036	item			SL036	item			SL036	item	1	
111	kit, AccuStick II Introducer System with RO Marker	SA071	kit			SA071	kit			SA071	kit			SA071	kit	1	
112	closed flush system, angiography	SC010	item			SC010	item			SC010	item			SC010	item	1	
113	sodium chloride 0.9% flush syringe	SH065	item			SH065	item			SH065	item			SH065	item	1	
114	guidewire	SD088	item			SD088	item			SD088	item			SD088	item	1	
115	dilator, vessel, angiographic	SD043	item			SD043	item			SD043	item			SD043	item	1	
116	drainage catheter, all purpose	SD161	item			SD161	item			SD161	item			SD161	item	1	
117	catheter percutaneous fastener (Percu-Stay)	SD146	item			SD146	item			SD146	item			SD146	item	1	
118	drainage pouch, nephrostomy-biliary	SD163	item			SD163	item			SD163	item			SD163	item	1	
119	tape, surgical paper 1in (Micropore)	SG079	in			SG079	in			SG079	in			SG079	in	12	
120	pack, moderate sedation	SA044	pack			SA044	pack			SA044	pack			SA044	pack	0	
121	gown, surgical, sterile	SB028	item			SB028	item			SB028	item			SB028	item	1	
122	film, x-ray, laser print	SK098	item			SK098	item			SK098	item			SK098	item	1	
123	tape, surgical occlusive 1 inch (Blenderm)	SG078	in	15		SG078	in			SG078	in	25		SG078	in		
124	**Equipment**																
125	Exam table	EF023		66		EF023				EF023		76		EF023			
126	Ultrasound room	EL015				EL015		33		EL015				EL015			
127	Film Alternator	ED024				ED024		58		ED024				ED024		58	
128	Laser printer	ER029				ER029		58		ER029				ER029		58	
129	CT room	EL007				EL007				EL007				EL007		43	
130	ECG, 3 channel	EL007				EL007				EL007				EL007		0	
131	IV fusion pump	EQ032				EQ032				EQ032				EQ032		0	
132	light, exam	EQ168				EQ168				EQ168				EQ168		60	
133	stretcher chair	EF019				EF019		15		EF019				EF019		15	
134	oxygen system, portable	EQ192				EQ192				EQ192				EQ192			
135	pulse oximeter w-printer	EQ211				EQ211				EQ211				EQ211			

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	**Tab 11: Revised 4/26/12**																		
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32002 (32422)**		**32422**				**76942**				**49061**				**76360 (77012)**	
3	**Meeting Date: April 2012** **Tab: 11** **Specialty: ACR: SIR**	**CMS CODE for 32422**	**CMS STAFF TYPE for 32422**	**Thoracentesis with insertion of tube catheter with or without water seal** **(PEAC Approved - Jan 2004)**		**Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)** **(Current RUC Database)**		**CMS CODE for 76942**	**CMS STAFF TYPE for 76942**	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **(PEAC Approved - Feb 2005)**		**CMS CODE for 49061**	**CMS STAFF TYPE for 49061**	**Drainage of retroperitoneal abscess; percutaneous** **(PEAC Approved - Jan 2004)**		**CMS CODE for 77012**	**CMS STAFF TYPE for 77012**	**Computed tomographic guidance for needle biopsy, radiological supervision and interpretation** **(PEAC Approved Jan 2004)**	
4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**			**XXX**	**XXX**			**000**	**000**			**XXX**	**XXX**
6	**TOTAL TIME**	**L041B**	**RT**	**79.0**	**31.0**	**79.0**	**31.0**	**L051B**	**RDMS**	**61.0**	**0.0**	**L037D**	**RN/LPN/MTA**	**11.0**	**0.0**	**L037D**	**RN/LPN/MTA**	**32.0**	**0.0**
7												**L041B**	**RT**	**55.0**					
8												**L051A**	**RN**	**77.0**					
9																			
10																			
11	**PRE-SERVICE**																		
12	**Start: Following visit when decision for surgery or procedure made**																		
13	Complete pre-service diagnostic & referral forms	L041B	RT	5	5	5	5												
14	Coordinate pre-surgery services	L041B	RT	3	10	3	10												
15	Schedule space and equipment in facility	L041B	RT	0	5		5												
16	Provide pre-service education/obtain consent	L041B	RT	5	5	5	5												
17	Follow-up phone calls & prescriptions	L041B	RT	3	3	3	3												
18	Other Clinical Activity (please specify): Retrieve prior images for comparison							L051B	RDMS	3						L037D	RN/LPN/MTA	6	
19	**End:When patient enters office/facility for surgery/procedure**																		
20	**SERVICE PERIOD**																		
21	**Start: When patient enters office/facility for surgery/procedure**																		
22	**Pre-service services**																		
23	Review charts	L041B	RT	2		2													
24	Greet patient and provide gowning	L041B	RT	3		3													
25	Obtain vital signs	L041B	RT	5		5												0	
26	Provide pre-service education/obtain consent													5 (RN/LPN/MTA)					
27	Prepare room, equipment, supplies	L041B	RT	2		2		L051B	RDMS	2				3 (RT)		L037D	RN/LPN/MTA	1	
28	Setup scope (non facility setting only)																		
29	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	2		2		L051B	RDMS	3				2 (RT)		L037D	RN/LPN/MTA	2	
30	Sedate/apply anesthesia													2 (RN)					
31	**Intra-service**																		
32	Acquire Image																		
33	Assist physician in performing procedure	L041B	RT	21		21		L051B	RDMS	45				48 (RT)		L037D	RN/LPN/MTA	18	
34	Assist physician - conscious sedation = physician time																		
35	-Assist with fluoroscopy/image acquisition (75%)																		
36	-Circulating throughout the procedure (25%)																		
37	**Post-Service**													60 (RN) @80%					

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
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4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
38	Monitor pt. following service/check tubes, monitors, drains	L041B	RT	15		15								15 (RN)					
39	Clean room/equipment by physician staff	L041B	RT	3		3		L051B	RDMS	3				2 (RT)		L037D	RN/LPN/MTA	3	
40	Clean Ultrasound																		
41	Clean Surgical Instrument Package																		
42	Complete diagnostic forms, lab & X-ray requisitions	L041B	RT	2		2								3 (RN/LPN/MTA)					
43	Review/read X-ray, lab, and pathology reports																		

	A	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
2	**Note**: 32002 was replaced by 32422 32020 was replaced by 32551 76360 was replaced by 77012			**32002 (32422)**		**32422**				**76942**				**49061**				**76360 (77012)**	
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4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L041B	RT	5		5								3 (RN/LPN/MTA)					
45	Discharge day management 99238 --12 minutes 99239 --15 minutes																		
46	Other Clinical Activity (please specify)																		
47	Process images, complete data sheet, present images and data to the interpreting physician							L051B	RDMS	5						L037D	RN/LPN/MTA	2	
48	**End: Patient leaves office**																		
49	**POST-SERVICE Period**																		
50	**Start: Patient leaves office/facility**																		
51	Conduct phone calls/call in prescriptions	L041B	RT	3	3	3	3												
52	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate																		
53	*List Number and Level of Office Visits*																		
54	99211 16 minutes																		
55	99212 27 minutes																		
56	99213 36 minutes																		
57	99214 53 minutes																		
58	99215 63 minutes																		
59	Other																		
60																			
61	*Total Office Visit Time*			0	0	0	0							0	0				
62	Other Activity (please specify)																		
64	**MEDICAL SUPPLIES**	CODE	UNIT					CODE	UNIT			CODE	UNIT			CODE	UNIT		
65	PEAC multispecialty supply package			1															
66	pack, minimum multi-specialty visit	SA048	pack			1		SA048	pack			SA048	pack			SA048	pack		
67	kit, thoracentesis (invoice provided)	SA070	tray	1		1		SA070	tray			SA070	tray			SA070	tray		
68	kit, pleural catheter insertion	SA077	kit					SA077	kit			SA077	kit			SA077	kit		
69	tray, shave prep	SA067	tray	1		1		SA067	tray			SA067	tray	1		SA067	tray		
70	mask, surgical, with face shield	SB034	item	2		2		SB034	item			SB034	item	2		SB034	item		
71	gloves, sterile	SB024	pair	2		2		SB024	pair			SB024	pair	1		SB024	pair		
72	gauze, sterile 4in x 4in	SG055	item	2		2		SG055	item			SG055	item	6		SG055	item		
73	gown, staff, impervious	SB027	item					SB027	item			SB027	item			SB027	item		
74	needle, 19-25g, butterfly	SC030	item					SC030	item			SC030	item			SC030	item		
75	gauze, sterile 4in x 4in (10 pack uou)	SG056	item					SG056	item			SG056	item			SG056	item		
76	gown, patient	SB026	item					SB026	item			SB026	item			SB026	item		
77	drape, non-sterile, sheet 40in x 60in	SB006	item					SB006	item			SB006	item			SB006	item		
78	gloves, non-sterile	SB022	pair					SB022	pair	1		SB022	pair			SB022	pair		
79	syringe 5-6ml	SC057	item					SC057	item			SC057	item			SC057	item		
80	paper, exam table	SB036	ft					SB036	ft			SB036	ft			SB036	ft		
81	cover, thermometer probe	SB004	item					SB004	item			SB004	item			SB004	item		
82	swab-pad, alcohol	SJ053	item					SJ053	item			SJ053	item			SJ053	item		
83	disinfectant spray (Transeptic)	SM012	ml					SM012	ml	10		SM012	ml			SM012	ml		
84	x-ray envelope	SK091	item					SK091	item	1		SK091	item			SK091	item	1	
85	film, x-ray 14in x 17in	SK034	item					SK034	item	3		SK034	item			SK034	item		
86	film, 8inx10in (ultrasound, MRI)	SK022	item					SK022	item	2		SK022	item			SK022	item		

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4	**LOCATION**			**Non Facility**	**Facility**	**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**			**Non Facility**	**Facility**
87	sanitizing cloth-wipe (patient)	SM021	item					SM021	item	2		SM021	item			SM021	item		
88	pillow case	SB037	item					SB037	item	1		SB037	item			SB037	item		
89	x-ray developer solution	SK089	oz					SK089	oz	1		SK089	oz			SK089	oz		
90	cover-condom, transducer or ultrasound probe	SB005	item					SB005	item	1		SB005	item			SB005	item		
91	lubricating jelly (Surgilube)	SJ033	oz					SJ033	oz	30		SJ033	oz			SJ033	oz		
92	computer media, dvd	SK013	item					SK013	item			SK013	item			SK013	item	1	
93	paper, exam table	SB036	ft					SB036	ft			SB036	ft			SB036	ft	7 feet	
94	cap, surgical	SB001	item					SB001	item			SB001	item	1		SB001	item		
95	shoe covers, surgical	SB039	pair					SB039	pair			SB039	pair	2		SB039	pair		
96	drape, sterile, three-quarter sheet	SB014	item					SB014	item			SB014	item	1		SB014	item		
97	drape-towel, sterile 18in x 26in	SB019	item					SB019	item			SB019	item	4		SB019	item		
98	drape, sterile, fenestrated 16in x 29in	SB011	item					SB011	item			SB011	item	1		SB011	item		
99	underpad 2ft x 3ft (Chux)	SB044	item					SB044	item			SB044	item	1		SB044	item		
100	povidone soln (Betadine)	SJ041	ml					SJ041	ml			SJ041	ml	60		SJ041	ml		
101	applicator, sponge-tipped	SG009	item					SG009	item			SG009	item	4		SG009	item		
102	lidocaine 1%-2% inj (Xylocaine)	SH047	ml					SH047	ml			SH047	ml	10		SH047	ml		
103	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item					SC058	item			SC058	item	2		SC058	item		
104	blade, surgical (Bard-Parker)	SF007	item					SF007	item			SF007	item	1		SF007	item		
105	stop cock, 3-way	SC049	item					SC049	item			SC049	item	1		SC049	item		
106	syringe 50-60ml	SC056	item					SC056	item			SC056	item	2		SC056	item		
107	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item					SH069	item			SH069	item	1		SH069	item		
108	cup, sterile, 8 oz	SL157	item					SL157	item			SL157	item	1		SL157	item		
109	cup, sterile, 12-16 oz	SL156	item					SL156	item			SL156	item	1		SL156	item		
110	cup, biopsy-specimen sterile 4oz	SL036	item					SL036	item			SL036	item	1		SL036	item		
111	kit, AccuStick II Introducer System with RO Marker	SA071	kit					SA071	kit			SA071	kit	1		SA071	kit		
112	closed flush system, angiography	SC010	item					SC010	item			SC010	item	1		SC010	item		
113	sodium chloride 0.9% flush syringe	SH065	item					SH065	item			SH065	item	1		SH065	item		
114	guidewire	SD088	item					SD088	item			SD088	item	1		SD088	item		
115	dilator, vessel, angiographic	SD043	item					SD043	item			SD043	item	1		SD043	item		
116	drainage catheter, all purpose	SD161	item					SD161	item			SD161	item	1		SD161	item		
117	catheter percutaneous fastener (Percu-Stay)	SD146	item					SD146	item			SD146	item	1		SD146	item		
118	drainage pouch, nephrostomy-biliary	SD163	item					SD163	item			SD163	item	1		SD163	item		
119	tape, surgical paper 1in (Micropore)	SG079	in					SG079	in			SG079	in	12		SG079	in		
120	pack, moderate sedation	SA044	pack					SA044	pack			SA044	pack	1		SA044	pack		
121	gown, surgical, sterile	SB028	item					SB028	item			SB028	item	1		SB028	item		
122	film, x-ray, laser print	SK098	item					SK098	item			SK098	item			SK098	item	1	
123	tape, surgical occlusive 1 inch (Blenderm)	SG078	in					SG078	in			SG078	in			SG078	in		
124	**Equipment**																		
125	Exam table	EF023		1		60		EF023				EF023				EF023			
126	Ultrasound room	EL015						EL015		X		EL015				EL015			
127	Film Alternator	ED024						ED024		58		ED024				ED024		1	
128	Laser printer	ER029						ER029		58		ER029				ER029		1	
129	CT room	EL007						EL007				EL007		60		EL007		22	
130	ECG, 3 channel	EL007						EL007				EL007		X		EL007			
131	IV fusion pump	EQ032						EQ032				EQ032		X		EQ032			
132	light, exam	EQ168						EQ168				EQ168		X		EQ168			
133	stretcher chair	EF019						EF019				EF019		X		EF019			
134	oxygen system, portable	EQ192						EQ192				EQ192		X		EQ192			
135	pulse oximeter w-printer	EQ211						EQ211				EQ211		X		EQ211			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Transcatheter Aortic Valve Replacement

In February 2012, the CPT Editorial Panel deleted four Category III code (0256T-0259T) and approved nine codes to report transcatheter aortic valve replacement procedures.

The RUC thoroughly discussed the unique nature of these services to understand and assign the appropriate valuation for these services. First, the members noted these services require two physicians, an interventional cardiologist and a cardiothoracic surgeon, be actively working on the patient during these procedures. Each operator has distinctly required work, which are specific to the operator's skill set, and are not duplicative between the two. For these reasons, the CMS National Coverage Determination (NCD) mandates that two physicians be present for this procedure to be completed. Second, the RUC recognized the intense nature of these procedures. Patients eligible for these procedures have previously been turned down for aortic valve replacement surgery and are receiving these procedures as a last resort. The NCD further mandates this patient population and there are currently no indications that these procedure will be approved for otherwise operable patients in the future. Finally, the RUC noted that the recommendations made by the Committee will value the total work of the service. Physician time includes the clock time of the procedure and does not constitute the addition of each physician's time. Payment policy issues, related to the co-surgery modifier and resulting payment modifications, were not determined, as it is outside the purview of the RUC. The RUC understands that CMS will consider these issues.

Prior to surveying, the specialty societies obtained approval from the Research Subcommittee to conduct an alternative methodology for surveying these services. To ensure the complete work of both physicians was captured, each survey was conducted concurrently by a thoracic surgeon and an interventional cardiologist.

33361 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach***
The RUC reviewed the survey data from 33 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 135 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

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The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 29.50, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33361 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33361, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC conducted the following methodology to ensure the recommended work value is relative to similar services. The Committee took CPT code 92986 *Percutaneous balloon valvuloplasty; aortic valve* (work RVU= 22.85, intra-service time= 113 minutes) and backed out the post-operative visits (remaining work RVU= 17.90) to ensure the comparison is based on a 000 day global equivalent. The difference between the two intra-service times (22 minutes) was multiplied by the IWPUT (0.16) and came to a value of 3.52. The value of 3.52 and 4.50 (the work RVU of 99291) were added to the base 17.90 work RVU of the balloon valvuloplasty code to arrive at a value of 25.92. The committee recognized that the surveyed code 33361 is a much more intense and complicated procedure compared to the balloon valvuloplasty service. **The RUC recommends a work RVU of 29.50 for CPT code 33361.**

33362 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach***
The RUC reviewed the survey data from 38 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 150 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 32.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33362 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33362, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC reviewed 33362 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 2.50 and increased time of 15 minutes. **The RUC recommends a work RVU of 32.00 for CPT code 33362.**

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33363 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach***
The RUC reviewed the survey data from 33 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 33.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33363 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33363, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC reviewed 33363 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 3.50 and increased time of 45 minutes. **The RUC recommends a work RVU of 33.00 for CPT code 33363.**

33364 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach***
The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 34.87, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33364 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33364, as described above, is a unique

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procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33364 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 5.37 and increased time of 45 minutes. The RUC noted that while 33364 and 33363 have the same intra-service times, 33364 is a more intense procedure due to the transplant incision and longer closure times. **The RUC recommends a work RVU of 34.87 for CPT code 33364.**

33365 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)***
The RUC reviewed the survey data from 30 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 37.50, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service time compared to the surveyed code, both services should be valued similarly given that 33365 is a more intense procedure, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33365 is a much more intense procedure. In addition, 33365, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33365 in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 8.00 and increased time of 45 minutes. The RUC noted that while 33365 and 33364 have the same intra-service times, 33364 is a more intense procedure due to complexities opening the chest via median sternotomy. **The RUC recommends a work RVU of 37.50 for CPT code 33365.**

0318T ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)***
The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 195 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is

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greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 40.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service time compared to the surveyed code, 0318T should be valued slightly higher due to greater intensity, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 0318T is a much more intense procedure. In addition, 0318T, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 0318T in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 10.50 and increased time of 60 minutes. **The RUC recommends a work RVU of 40.00 for CPT code 0318T.**

Add-On Services
The RUC noted that the three add-on cardiopulmonary bypass support services (33367-X9) are only reported by the thoracic surgeon and not performed by two physicians. These procedures are performed during standard transcatheter aortic valve replacement services upon the patient becoming hemodynamically unstable and cannot be stabilized by any standard medical means.

33367 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)***
The RUC reviewed the survey results from 35 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 90 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 11.88 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 37223 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 4.25) and agreed that the surveyed code has double the intra-service time and is a more intense procedure. Given this, 33367 should be valued much higher. In addition, CPT code 22845 *Anterior instrumentation; 2 to 3 vertebral segments* (work RVU= 11.94) was compared to 33367 and the RUC noted that the two services have identical intra-service time, 90 minutes, with comparable physician work, and should be valued similarly. **The RUC recommends a work RVU of 11.88 for CPT code 33367.**

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33368 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)***
The RUC reviewed the survey results from 34 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 120 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 14.39 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 33960 *Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day* (work RVU= 10.59, valued as a ZZZ global service) and agreed that while the reference code has slightly greater intra-service time, 13 minutes, compared to 33368, the surveyed code is a more intense procedure and should be valued higher. In addition, the RUC reviewed CPT code 22843 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments* (work RVU= 13.44, intra-time= 120 minutes) and agreed that with identical intra-service time the surveyed code should be valued slightly higher due to greater intensity. **The RUC recommends a work RVU of 14.39 for CPT code 33368.**

33369 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)***
The RUC reviewed the survey results from 35 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 160 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 19.00 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 33305 Repair of cardiac wound; with cardiopulmonary bypass (work RVU= 29.60, valued as a ZZZ global period) and agreed that while the surveyed code is a more intense procedure, the reference code should be valued higher due to greater intra-service time, 296 minutes compared to 160 minutes. In addition, the RUC reviewed CPT code 22844 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments* (work RVU= 16.42, intra-service time= 150 minutes) and agreed that since the surveyed code has greater intra-service time and a higher intensity the value should be higher for 33369. **The RUC recommends a work RVU of 19.00 for CPT code 33369.**

Practice Expense: The TAVR codes represent procedures that will be performed in the facility 100% of the time and will require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment. Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather then the RN staff type typical to the cardiothoracic surgery codes. The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

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New Technology: These services will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

RUC Database: These services will be flagged in the RUC database so they are not used to validate the physician work of other services in the RBRVS.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

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Codes 33361-33365, 0318T are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are coded using modifier 62.

Codes 33361–33365, 0318T include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes 33362–33365, 0318T also include open arterial or cardiac approach.

Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes.

Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supravalvular aortography code (93567) should ~~NOT~~ **not** be used with TAVR/TAVI services (33361-33365, 0318T) to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TAVR/TAVI,
2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI, or
3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the TAVR/TAVI services codes (33361-33365, 0318T).

Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately reportable if:

1. No prior catheter-based coronary angiography study is available and a full diagnostic study is performed, OR
2. A prior study is available, but as documented in the medical record:
    a. The patient's condition with respect to the clinical indication has changed since the prior study, OR
    b. There is inadequate visualization of the anatomy and/or pathology, OR
    c. There is a clinical change during the procedure that requires new evaluation.
    d. For same session/same day diagnostic coronary angiography services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TAVR/TAVI

Other cardiac catheterization services are reported separately when performed for diagnostic purposes not intrinsic to TAVR/TAVI.

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Percutaneous coronary interventional procedures are reported separately, when performed.

When transcatheter ventricular support is required in conjunction with TAVR/TAVI, the appropriate code should be reported with the appropriate ventricular assist device (VAD) procedure code (33990-33993, 33975, 33976, 33999) or balloon pump insertion code (33967, 33970, 33973)

The TAVR/TAVI cardiovascular access and delivery procedures are reported with 33361-33365, 0318T. When cardiopulmonary bypass is performed in conjunction with TAVR/TAVI, codes 33361-33365, 0318T should be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369)

●33361	GG1	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	000	29.50
●33362	GG2	open femoral artery approach	000	32.00
●33363	GG3	open axillary artery approach	000	33.00
●33364	GG4	open iliac artery approach	000	34.87
●33365	GG5	transaortic approach (eg, median sternotomy, mediastinotomy)	000	37.50

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●0318T	GG6	transapical approach (eg, left thoracotomy) (For percutaneous femoral artery, open femoral artery, open axillary artery, open iliac artery, or transaortic approach, see 33361-33365) (When cardiopulmonary bypass is used with code 0318T, report with the appropriate add-on code +33367, +33368, or +33369)	000	40.00
●+33367	GG7	cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure) (Use 33367 in conjunction with 33361-33366) (Do not report 33367 in conjunction with 33368 or 33369)	ZZZ	11.88
●+33368	GG8	cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure) (Use 33368 in conjunction with 33361-33366) (Do not report 33368 in conjunction with 33367,33369)	ZZZ	14.39
●+33369	GG9	cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure) (Use 33369 in conjunction with 33361-33366) (Do not report 33369 in conjunction with 33367, 33368)	ZZZ	19.00
D0256T		~~Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach~~	YYY	N/A

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D0257T		~~Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular)~~	YYY	N/A
D0258T		~~Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass~~	YYY	N/A
D0259T		~~Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass~~	YYY	N/A
(0256T has been deleted. To report, see 33361-33364) (0257T has been deleted. To report, see 33365, 0318T) (0258T has been deleted. To report, see 33365, 0318T) (0259T has been deleted. To report, see 33365-33369, 0318T)				

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33361 Tracking Number GG1 Original Specialty Recommended RVU: **29.50**
Presented Recommended RVU: **29.50**
Global Period: 000 RUC Recommended RVU: **29.50**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. Invasive monitoring with a radial arterial and pulmonary arterial catheter is established . External defibrillator pads are placed on the anterior and posterior chest. A transesophageal echo probe is inserted for intraoperative monitoring. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on the operative field. Critical personnel, including surgeons, interventional

cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

Description of Intra-Service Work: A temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

Femoral arterial access is obtained (Seldinger technique) for the valve delivery system. Angiography of the access vessel is performed to confirm anatomical suitability of the vessel for passage of the delivery catheter. Using fluoroscopic guidance, a standard guidewire is advanced to the descending aorta and exchanged for a stiff guidewire with an angiographic catheter. Over the stiff guidewire, the arteriotomy is progressively enlarged with dilators, and a large-bore vessel introducer sheath is inserted and advanced to a level that is inferior to the renal arteries. The guidewire is removed and antithrombotic therapy is administered to achieve therapeutic anticoagulation levels.

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle and the wire is exchanged for a stiff guide wire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained, requiring repositioning. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guidewire, and sheath are removed from the patient. The opening of the access artery is closed, typically via direct suture or with percutaneous suture. Percutaneous closure requires at least two separate suture delivery catheters due to the large size of the arteriotomy. The access site is monitored for adequate hemostasis. If heparin was administered, it may be reversed using protamine. A sterile dressing is applied to the entry site

Description of Post-Service Work: The physicians confirm the patient hemodynamic status,including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed

assessing for adequate limb perfusion. Post operative orders are written. A detailed “hand-off” process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient’s fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post-operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC, SCAI		
CPT Code:	33361		
Sample Size:	70	**Resp N:** 33	**Response:** 47.1 %
Description of Sample:	Targeted. As approved by the Research Subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	15.00	100.00
Survey RVW:	6.74	25.13	**29.50**	35.00	50.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**30.00**		
Intra-Service Time:	30.00	120.00	**135.00**	180.00	300.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33361	**Recommended Physician Work RVU: 29.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**135.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33880	000	27.28	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of Research Subcommittee for use on RSL for code

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

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

CPT Descriptor 1 see separate table for MPC references

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33881	000	22.21	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of Research Subcommittee for use on RSL for code

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

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 42.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 33361**	**Key Reference CPT Code:** 33880	**Source of Time** **RUC Time**
Median Pre-Service Time	85.00	130.00	
Median Intra-Service Time	135.00	225.00	

Median Immediate Post-service Time	45.00	45.00
Median Critical Care Time	70.0	55.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**335.00**	**455.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)	
The number of possible diagnosis and/or the number of management options that must be considered	4.50 / 3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57 / 3.50
Urgency of medical decision making	3.86 / 3.29
Technical Skill/Physical Effort (Mean)	
Technical skill required	4.43 / 3.36
Physical effort required	4.00 / 3.43
Psychological Stress (Mean)	
The risk of significant complications, morbidity and/or mortality	4.43 / 3.36
Outcome depends on the skill and judgment of physician	4.50 / 3.57
Estimated risk of malpractice suit with poor outcome	3.71 / 3.43

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.71	3.29
Intra-Service intensity/complexity	4.93	3.50
Post-Service intensity/complexity	4.57	2.79

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were members of teams of co-operators who participated in clinical trials of these new devices.

JOINT OPERATORS FOR THE PROCEDURES

There are nine codes included in the transcatheter aortic valve replacement (TAVR) procedures. Six codes represent the various approaches and insertion of the TAVR. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon from institutions that were/are involved with clinical trials for the TAVR procedures. The survey was distributed to 70 institutions and over 140 physicians. There are three add-on codes to report when cardiopulmonary bypass is employed to support the patient during the procedure.

For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure.

Medicare's proposed National Coverage Decision, and the joint statements of the American College of Cardiology and the Society of Thoracic Surgeons mandate the performance of these procedures by two physicians. The relevant section is as follows:

4. The procedure is performed by physicians with the following qualifications and experience:
    a. Surgeon requirements:
        i. Board Certified/Eligible in Cardiovascular Surgery;
        ii. Professional experience with:
            1. ≥ 100 AVR/career including 10 high risk patients; OR
            2. ≥ 25 AVR/year or 50 AVR in 2 years; AND
            3. ≥ 20 in the last year prior to TAVR.
    b. Interventionalist requirements:
        i. Operators must be Board Certified/Eligible in Interventional Cardiology
        ii. Professional experience with 50 structural heart disease procedures

This will result in the **required use of the -62 modifier** for 33361-33366 and result in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes. Based upon this, the following describes the individual IWPUT for the proposed work values:

CPT Code: 33361

IWPUT Calculator				
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach			
Building Block Method			**RVW**	**-62 Mod RVW**
Proposed RVW			**29.50**	**18.44**
Pre-service	**Time**	**Intensity**	**-62 Mod Intensity**	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
Pre-service total				**1.01**
Post-service	**Time**	**Intensity**	**-62 Mod Intensity**	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	**Visit n**	**E/M RVU**	**-62 Mod E/M RVU**	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
Post-service total				**3.44**
	Time		**IWPUT**	
Intra-service	135		**0.1036**	**13.98375**

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the MPC list.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery. The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0256T Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach

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

Specialty Cardiology and Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 990
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovasular approaches (3300) 33361 ercutaneous 30%, 33362 femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery Frequency 990 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 940
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery Frequency 940 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33880

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33362 Tracking Number GG2 Original Specialty Recommended RVU: **32.00**
Presented Recommended RVU: **32.00**
Global Period: 000 RUC Recommended RVU: **32.00**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. The femoral vessels are found to be unsuitable for percutaneous cannulation, and an open femoral approach is utilized.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on the operative field. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and

perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

Description of Intra-Service Work: A temporary transvenous pacemaker electrode is advanced into apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

A skin incision is made in the inguinal region. The subcutaneous tissue is dissected until the common femoral artery is isolated. Care is taken to avoid injury to the femoral nerve and vein that lie in close proximity. The common, superficial, and deep femoral arteries are dissected and captured in vessel loops. The distal external iliac artery is typically included in the dissection. This approach facilitates introduction of the very large diameter sheath required for delivery of the transcatheter aortic valve. It also serves to apply countertraction and temporarily reduce tortuosity of the iliac arteries as the sheath is advanced. Intravenous anti-thrombotic therapy is begun. Angiography of the access vessel is performed to confirm anatomical suitability of the vessel for passage of the delivery catheter. A transverse arteriotomy is made in the anterior surface of the common femoral or distal-most external iliac artery. If necessary an end-side prosthetic graft is sewn in place to facilitate catheter delivery and/or preserve distal leg perfusion.

Using fluoroscopic guidance, a standard guidewire is advanced to the descending aorta and exchanged for a stiff guidewire with an angiographic catheter. Over the stiff guidewire a large-bore vessel introducer sheath is inserted and advanced to a level that is inferior to the renal arteries.

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle and the wire is exchanged for a stiff guide wire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained, requiring repositioning. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guide wire, and sheath are removed from the patient.

The femoral arteriotomy is repaired with very fine (e.g. 6-0 polypropylene) sutures. Hemostasis is achieved, the wound irrigation, and the soft tissue is re-approximated in several layers. Skin closure is performed with staples or sutures.

Description of Post-Service Work: The physicians confirm the patient hemodynamic status,including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed assessing for adequate limb perfusion. Post operative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC, SCAI		
CPT Code:	33362		
Sample Size:	70	**Resp N:** 38	**Response:** 54.2 %
Description of Sample:	Targeted. As approved by the Research Subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**14.00**	30.00	250.00
Survey RVW:	11.34	27.52	**32.00**	35.59	54.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**30.00**		
Intra-Service Time:	30.00	120.00	**150.00**	195.00	300.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33362	**Recommended Physician Work RVU: 32.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**150.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33880	000	27.28	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of research subcommittee for use on RSL for code

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

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

CPT Descriptor 1 see separate table for MPC references

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33979	XXX	37.50	**RUC Time**

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

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

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33362**	**Key Reference CPT Code:** 33880	**Source of Time** **RUC Time**
Median Pre-Service Time	85.00	130.00	
Median Intra-Service Time	150.00	225.00	
Median Immediate Post-service Time	45.00	45.00	
Median Critical Care Time	70.0	55.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**350.00**	**455.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.79	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.95	4.16
Urgency of medical decision making	4.00	3.68
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.95	4.37
Physical effort required	4.26	3.95
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.84	4.21
Outcome depends on the skill and judgment of physician	4.95	4.37
Estimated risk of malpractice suit with poor outcome	3.89	3.79

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.68	4.32
Intra-Service intensity/complexity	4.95	4.63
Post-Service intensity/complexity	4.53	4.26

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were members of teams of co-operators who participated in clinical trials of these new devices.

JOINT OPERATORS FOR THE PROCEDURES

There are nine codes included in the transcatheter aortic valve replacement (TAVR) procedures. Six codes represent the various approaches and insertion of the TAVR. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon from institutions that were/are involved with clinical trials for the TAVR procedures. The survey was distributed to 70 institutions and over 140 physicians. There are three add-on codes to report when cardiopulmonary bypass is employed to support the patient during the procedure.

For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure.

Medicare's proposed National Coverage Decision, and the joint statements of the American College of Cardiology and the Society of Thoracic Surgeons mandate the performance of these procedures by two physicians. The relevant section is as follows:

4. The procedure is performed by physicians with the following qualifications and experience:
    a. Surgeon requirements:
        i. Board Certified/Eligible in Cardiovascular Surgery;
        ii. Professional experience with:
            1. ≥ 100 AVR/career including 10 high risk patients; OR
            2. ≥ 25 AVR/year or 50 AVR in 2 years; AND
            3. ≥ 20 in the last year prior to TAVR.
    b. Interventionalist requirements:
        . Operators must be Board Certified/Eligible in Interventional Cardiology
        i. Professional experience with 50 structural heart disease procedures

This will result in the **required use of the -62 modifier** for 33361-33366 and result in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes. Based upon this, the following describes the individual IWPUT for the proposed work values:

IWPUT Calculator				
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach			
Building Block Method			**RVW**	**-62 Mod RVW**
Proposed RVW			**32.00**	**20.00**
Pre-service	**Time**	**Intensity**	**-62 Mod Intensity**	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
Pre-service total				**1.01**
Post-service	**Time**	**Intensity**	**-62 Mod Intensity**	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	**Visit n**	**E/M RVU**	**-62 ModE/M RVU**	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
Post-service total				**3.44**
	Time		**IWPUT**	
Intra-service	150		**0.1036**	**15.54625**

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the current MPC list.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency on the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery. The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0256T Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach

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

Specialty Cardiology and Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1716
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovasular approaches (3300) 33361 ercutaneous 30%, 33362 femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery Frequency 1716 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,630
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery Frequency 1630 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33880

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33363 Tracking Number GG3 Original Specialty Recommended RVU: **33.00**
Presented Recommended RVU: **33.00**
Global Period: 000 RUC Recommended RVU: **33.00**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. The patient has severe aortoiliac occlusive disease that precludes the femoral or iliac arterial approach for prosthesis delivery.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on the operative field. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and

perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure..

Description of Intra-Service Work: A temporary transvenous pacemaker electrode is advanced into apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

A subclavicular incision is made, and the subcutaneous tissue is dissected until the axillary artery is located. Care is taken to avoid injury to the axillary nerve and vein that lie in close proximity. Once adequate approach is achieved and intravenous antithrombotic therapy begun, proximal and distal vascular clamps are applied. A longitudinal arteriotomy is made. The conduit (a large diameter tubular segment of synthetic bypass graft) is brought onto the field, tailored to appropriate size, and an anastomosis of conduit to axillary artery is sutured with fine polypropylene. The conduit is clamped and vascular clamps are removed from the axillary artery. The suture line is checked for hemostasis and additional sutures are applied as required. A sheath is passed over a guidewire through the graft and a pigtail angiographic catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. Typically, several aortograms in different angles are required.

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle and the wire is exchanged for a stiff guide wire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained, requiring repositioning. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guide wire, and sheath are removed from the patient.

The axillary artery is then clamped with a partial occlusion clamp to isolate the graft, which is excised leaving a 5-6 mm cuff. This is oversewn in two layers with polypropylene suture, deaired, and the clamp removed. Hemostasis is achieved. The wound is irrigated and closed in layers.

Description of Post-Service Work: The physicians confirm the patient hemodynamic status,including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed assessing for adequate limb perfusion. Post operative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD				
Specialty(s):	STS, ACC, SCAI				
CPT Code:	33363				
Sample Size:	70	**Resp N:**	33	**Response:** 47.1 %	
Description of Sample:	Targeted. As approved by the Research Subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	3.00	43.00
Survey RVW:	11.34	28.50	**33.00**	37.50	58.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**30.00**		
Pre-Service Scrub, Dress, Wait Time:			**30.00**		
Intra-Service Time:	70.00	130.00	**180.00**	200.00	330.00

Immediate Post Service-Time:	**53.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33363	**Recommended Physician Work RVU: 33.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33880	000	27.28	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of research subcommittee for use on RSL for code

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

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

CPT Descriptor 1 see separate table for MPC references

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33979	XXX	37.50	**RUC Time**

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

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 39.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 33363**	**Key Reference CPT Code:** 33880	**Source of Time RUC Time**
Median Pre-Service Time	85.00	130.00	
Median Intra-Service Time	180.00	225.00	
Median Immediate Post-service Time	45.00	45.00	
Median Critical Care Time	70.0	55.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**380.00**	**455.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.86	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.86	3.79
Urgency of medical decision making	4.43	3.64
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	3.71
Physical effort required	4.50	3.64
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.86	3.79
Outcome depends on the skill and judgment of physician	5.00	3.86
Estimated risk of malpractice suit with poor outcome	4.00	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.64	3.64
Intra-Service intensity/complexity	4.93	3.93
Post-Service intensity/complexity	4.50	3.64

Additional Rationale and Comments

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

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    a. Surgeon requirements:
        i. Board Certified/Eligible in Cardiovascular Surgery;
        ii. Professional experience with:
            1. ≥ 100 AVR/career including 10 high risk patients; OR
            2. ≥ 25 AVR/year or 50 AVR in 2 years; AND
            3. ≥ 20 in the last year prior to TAVR.
    b. Interventionalist requirements:
        . Operators must be Board Certified/Eligible in Interventional Cardiology
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IWPUT Calculator				
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Proposed RVW			**33.00**	**20.63**
Pre-service	**Time**	**Intensity**	**-62 Mod Intensity**	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
Pre-service total				**1.01**
Post-service	**Time**	**Intensity**	**-62 Mod Intensity**	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	**Visit n**	**E/M RVU**	**-62 ModE/M RVU**	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
Post-service total				**3.44**
	Time		**IWPUT**	
Intra-service	180		**0.0898**	**16.17125**

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the current MPC list.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency on the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery.
The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0256T Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach

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

Specialty Cardiology and Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 330
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovasular approaches (3300) 33361 ercutaneous 30%, 33362 femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery Frequency 330 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 313
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery Frequency 313 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33880

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33364 Tracking Number GG4 Original Specialty Recommended RVU: **34.87**
Presented Recommended RVU: **34.87**
Global Period: 000 RUC Recommended RVU: **34.87**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. Preoperative studies indicate that the femoral vessels are too small and diseased to permit either the percutaneous or open femoral arterial approach for prosthesis delivery and therefore an open iliac approach is selected.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on the operative field. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and

perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

Description of Intra-Service Work: A temporary transvenous pacemaker electrode is advanced into apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

A transverse suprainguinal skin incision is made and a retroperitoneal dissection plane is developed. The dissection is continued deep into the pelvis until the iliac artery is located. Care is taken to avoid injury to the nerves, veins, and ureter that lie in close proximity. The common, internal, and external iliac arteries are dissected and isolated with vessel loops. Intravenous antithrombotic therapy is administered. A longitudinal arteriotomy is made. A graft conduit (a large diameter tubular segment of synthetic bypass graft) is brought onto the field, tailored to appropriate size, and an end-to-side anastomosis of conduit to common iliac artery is sutured with fine polypropylene. The conduit is clamped and vascular clamps are removed. The suture line is checked for hemostasis and additional sutures are applied as required. A sheath is passed over a guidewire through the graft and a pigtail angiographic catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. Typically, several aortograms in different angles are required.

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle and the wire is exchanged for a stiff guide wire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained, requiring repositioning. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guide wire, and sheath are removed from the patient.

The iliac arterial graft site is then clamped with a partial occlusion clamp to isolate the graft, which is excised leaving a 5-6 mm cuff. This is oversewn in two layers with polypropylene suture, deaired, and the clamp removed. Hemostasis is achieved. The wound is irrigated and closed in layers.

Description of Post-Service Work: The physicians confirm the patient hemodynamic status,including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed assessing for adequate limb perfusion. Post operative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into theSmandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD				
Specialty(s):	STS, ACC, SCAI				
CPT Code:	33364				
Sample Size:	70	**Resp N:**	31	**Response:** 44.2 %	
Description of Sample:	Targeted. As approved by the Research Subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	2.00	45.00
Survey RVW:	8.80	30.00	**34.87**	39.74	65.00
Pre-Service Evaluation Time:			**53.00**		
Pre-Service Positioning Time:			**25.00**		
Pre-Service Scrub, Dress, Wait Time:			**30.00**		
Intra-Service Time:	70.00	150.00	**180.00**	240.00	330.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33364	**Recommended Physician Work RVU: 34.87**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33880	000	27.28	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of research subcommittee for use on RSL for code

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

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

CPT Descriptor 1 see separate table for MPC references

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33979	XXX	37.50	**RUC Time**

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

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 48.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 33364**	**Key Reference CPT Code:** 33880	**Source of Time** **RUC Time**
Median Pre-Service Time	85.00	130.00	
Median Intra-Service Time	180.00	225.00	
Median Immediate Post-service Time	45.00	45.00	
Median Critical Care Time	70.0	55.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**380.00**	**455.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.67	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.93	3.60
Urgency of medical decision making	4.33	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	3.80
Physical effort required	4.67	3.60
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.87	3.67
Outcome depends on the skill and judgment of physician	4.93	4.00
Estimated risk of malpractice suit with poor outcome	3.73	3.47

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.53	3.53
Intra-Service intensity/complexity	4.93	3.80
Post-Service intensity/complexity	4.07	3.60

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were members of teams of co-operators who participated in clinical trials of these new devices.

JOINT OPERATORS FOR THE PROCEDURES

There are nine codes included in the transcatheter aortic valve replacement (TAVR) procedures. Six codes represent the various approaches and insertion of the TAVR. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon from institutions that were/are involved with clinical trials for the TAVR procedures. The survey was distributed to 70 institutions and over 140 physicians. There are three add-on codes to report when cardiopulmonary bypass is employed to support the patient during the procedure.

For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure.

Medicare's proposed National Coverage Decision, and the joint statements of the American College of Cardiology and the Society of Thoracic Surgeons mandate the performance of these procedures by two physicians. The relevant section is as follows:

4. The procedure is performed by physicians with the following qualifications and experience:
    a. Surgeon requirements:
        i. Board Certified/Eligible in Cardiovascular Surgery;
        ii. Professional experience with:
            1. ≥ 100 AVR/career including 10 high risk patients; OR
            2. ≥ 25 AVR/year or 50 AVR in 2 years; AND
            3. ≥ 20 in the last year prior to TAVR.
    b. Interventionalist requirements:
        . Operators must be Board Certified/Eligible in Interventional Cardiology
        i. Professional experience with 50 structural heart disease procedures

This will result in the **required use of the -62 modifier** for 33361-33366 and result in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes. Based upon this, the following describes the individual IWPUT for the proposed work values:

IWPUT Calculator				
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach			
Building Block Method			**RVW**	**-62 Mod RVW**
Proposed RVW			**34.87**	**21.79**
Pre-service	**Time**	**Intensity**	**-62 Mod Intensity**	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
Pre-service total				**1.01**
Post-service	**Time**	**Intensity**	**-62 Mod Intensity**	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	**Visit n**	**E/M RVU**	**-62 ModE/M RVU**	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
Post-service total				**3.44**
	Time		**IWPUT**	
Intra-service	180		**0.0963**	**17.34000**

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the current MPC list.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency on the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery.
The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0256T Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach

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

Specialty Cardiology and Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 264
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovasular approaches (3300) 33361 ercutaneous 30%, 33362 femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery Frequency 264 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery Frequency 250 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33880

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33365 Tracking Number GG5 Original Specialty Recommended RVU: **37.50**
Presented Recommended RVU: **37.50**
Global Period: 000 RUC Recommended RVU: **37.50**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. Because of severe peripheral vascular disease, including severe aortoiliac, femoral and axillary artery disease, along with severe pulmonary disease that precludes a transapical approach, a direct aortic approach is recommended via either median sternotomy or mediastinotomy.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 600%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on

the operative field. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

Description of Intra-Service Work: A temporary transvenous pacemaker electrode is advanced into apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. .

A full or partial median sternotomy incision is performed.. Dissection of the thymic fat pad reveals the pericardium, which is opened vertically and sutures used to retract and expose the ascending aorta. Alternatively an anterior mediastinotomy is performed providing access to the ascending aorta. Antithromotic therapy is begun. Epiaortic ultrasonic scanning is performed to identify a disease free site for sheath delivery. A pledgeted double pursestring suture is placed in the mid ascending aorta and the adventia locally dissected within the pursestring. The aorta is opened with a knife, the vascular sheath introduced, and the pursestring tightened to achieve hemostasis. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. Typically, several aortograms in different angles are required??

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle and the wire is exchanged for a stiff guide wire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained, requiring repositioning. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter and guide wire are removed from the patient.

The sheath is removed from the ascending aorta and the aortic double pursestring suture tied. Additional sutures may be required for hemostasis. The pericardium is closed over a single drain. Anticoagulation is reversed. After achieving

satisfactory hemostasis, the sternum is reapproximated with stainless steel wires. The wound is irrigated and closed in layers.

Description of Post-Service Work: The physicians confirm the patient hemodynamic status,including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed assessing for adequate limb perfusion. Post operative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD				
Specialty(s):	STS, ACC, SCAI				
CPT Code:	33365				
Sample Size:	70	**Resp N:**	30	**Response:** 42.8 %	
Description of Sample:	Targeted. As approved by the Research Subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	4.00	47.00
Survey RVW:	10.50	30.00	**37.50**	40.00	56.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**30.00**		
Pre-Service Scrub, Dress, Wait Time:			**30.00**		
Intra-Service Time:	45.00	175.00	**180.00**	210.00	340.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33365	**Recommended Physician Work RVU: 37.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	XXX	37.50	**RUC Time**

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

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

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

CPT Descriptor 1 see separate table for MPC references

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33880	000	27.28	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of research subcommittee for use on RSL for code

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33365**	**Key Reference CPT Code:** 33979	**Source of Time** **RUC Time**
Median Pre-Service Time	85.00	95.00	
Median Intra-Service Time	180.00	280.00	
Median Immediate Post-service Time	45.00	120.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**380.00**	**495.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.63	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.69	3.88
Urgency of medical decision making	4.31	3.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.69	3.88
Physical effort required	4.50	3.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.69	3.94
Outcome depends on the skill and judgment of physician	4.56	3.94
Estimated risk of malpractice suit with poor outcome	3.94	3.19

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.56	3.88
Intra-Service intensity/complexity	4.69	4.00
Post-Service intensity/complexity	4.44	3.88

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were members of teams of co-operators who participated in clinical trials of these new devices.

JOINT OPERATORS FOR THE PROCEDURES

There are nine codes included in the transcatheter aortic valve replacement (TAVR) procedures. Six codes represent the various approaches and insertion of the TAVR. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon from institutions that were/are involved with clinical trials for the TAVR procedures. The survey was distributed to 70 institutions and over 140 physicians. There are three add-on codes to report when cardiopulmonary bypass is employed to support the patient during the procedure.

For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure.

Medicare's proposed National Coverage Decision, and the joint statements of the American College of Cardiology and the Society of Thoracic Surgeons mandate the performance of these procedures by two physicians. The relevant section is as follows:

4. The procedure is performed by physicians with the following qualifications and experience:
    a. Surgeon requirements:
        i. Board Certified/Eligible in Cardiovascular Surgery;
        ii. Professional experience with:
            1. ≥ 100 AVR/career including 10 high risk patients; OR
            2. ≥ 25 AVR/year or 50 AVR in 2 years; AND
            3. ≥ 20 in the last year prior to TAVR.
    b. Interventionalist requirements:
        . Operators must be Board Certified/Eligible in Interventional Cardiology
        i. Professional experience with 50 structural heart disease procedures

This will result in the **required use of the -62 modifier** for 33361-33366 and result in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes. Based upon this, the following describes the individual IWPUT for the proposed work values:

IWPUT Calculator				
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)			
Building Block Method			**RVW**	**-62 Mod RVW**
Proposed RVW			**37.50**	**23.44**
Pre-service	**Time**	**Intensity**	**-62 Mod Intensity**	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
Pre-service total				**1.01**
Post-service	**Time**	**Intensity**	**-62 Mod Intensity**	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	**Visit n**	**E/M RVU**	**-62 ModE/M RVU**	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
Post-service total				**3.44**
	Time		**IWPUT**	
Intra-service	180		**0.1055**	**18.98375**

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the current MPC list.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency on the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery.
The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0257T Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular) and 0258T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass

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

Specialty Cardiology and Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 510
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovasular approaches (3300) 33361 ercutaneous 30%, 33362 femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery Frequency 510 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 484
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery Frequency 484 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0318T Tracking Number GG6 Original Specialty Recommended RVU: **40.00**
Presented Recommended RVU: **40.00**
Global Period: 000 RUC Recommended RVU: **40.00**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. Because of severe peripheral vascular disease, including severe aortoiliac, femoral axillary artery disease, and the presence of a porcelain aorta, a transapical approach is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

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

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on

the operative field. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

Description of Intra-Service Work: A temporary transvenous pacemaker electrode is advanced into apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

The heart is exposed through a left anterior thoracotomy in the fifth or sixth intercostal space. Single lung ventilation is initiated and the left lung is collapsed. A pericardiotomy is performed, and pacing wires are affixed to the ventricular muscle. Two circumferential pledgeted pursestring sutures are placed in the apex of the left ventricle. Anticoagulant therapy is administered to achieve therapeutic anticoagulation levels. A sheath is introduced into the left ventricle, and a pigtail catheter advanced over a guidewire into the ascending aorta using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. Typically, several aortograms in different angles are required

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the aorta, a small catheter is advanced over the wire and the wire is exchanged for a stiff guide wire. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced across the native aortic valve annulus to the aortic root and positioned under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter and guide wire are removed from the patient.

The LV apical sheath is removed and the pursestring sutures are tied. Hemostasis is assured. Protamine is given to reverse the heparin. Chest tube(s) are placed. Double lung ventilation is resumed. The incision is closed in layers and dressings are placed.

Description of Post-Service Work: The physicians confirm the patient hemodynamic status,including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed

assessing for adequate limb perfusion. Post operative orders are written. A detailed “hand-off” process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient’s fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	0318T		
Sample Size:	70	**Resp N:** 31	**Response:** 44.2 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	11.00	60.00
Survey RVW:	22.21	32.00	**40.00**	43.13	56.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**30.00**		
Pre-Service Scrub, Dress, Wait Time:			**30.00**		
Intra-Service Time:	75.00	173.00	**195.00**	225.00	340.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	0318T	**Recommended Physician Work RVU: 40.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**195.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	ZZZ	37.50	**RUC Time**

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

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

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

CPT Descriptor 1 see separate table for MPC references

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33880	000	27.28	**RUC Time**

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
*Code global and RVU has been adjusted to represent a 000 day global value per approval of research subcommittee for use on RSL for code

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 58.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 0318T**	**Key Reference CPT Code:** 33979	**Source of Time** **RUC Time**
Median Pre-Service Time	85.00	95.00	
Median Intra-Service Time	195.00	280.00	
Median Immediate Post-service Time	45.00	120.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**395.00**	**495.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.35	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	4.00
Urgency of medical decision making	4.06	3.82
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.41	4.06
Physical effort required	4.35	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.41	4.00
Outcome depends on the skill and judgment of physician	4.41	4.06
Estimated risk of malpractice suit with poor outcome	3.76	3.53

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.35	3.88
Intra-Service intensity/complexity	4.41	4.12
Post-Service intensity/complexity	3.88	4.00

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were members of teams of co-operators who participated in clinical trials of these new devices.

JOINT OPERATORS FOR THE PROCEDURES

There are nine codes included in the transcatheter aortic valve replacement (TAVR) procedures. Six codes represent the various approaches and insertion of the TAVR. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon from institutions that were/are involved with clinical trials for the TAVR procedures. The survey was distributed to 70 institutions and over 140 physicians. There are three add-on codes to report when cardiopulmonary bypass is employed to support the patient during the procedure.

For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure.

Medicare's proposed National Coverage Decision, and the joint statements of the American College of Cardiology and the Society of Thoracic Surgeons mandate the performance of these procedures by two physicians. The relevant section is as follows:

4. The procedure is performed by physicians with the following qualifications and experience:
    a. Surgeon requirements:
        i. Board Certified/Eligible in Cardiovascular Surgery;
        ii. Professional experience with:
            1. ≥ 100 AVR/career including 10 high risk patients; OR
            2. ≥ 25 AVR/year or 50 AVR in 2 years; AND
            3. ≥ 20 in the last year prior to TAVR.
    b. Interventionalist requirements:
        . Operators must be Board Certified/Eligible in Interventional Cardiology
        i. Professional experience with 50 structural heart disease procedures

This will result in the **required use of the -62 modifier** for 33361-33366 and result in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes. Based upon this, the following describes the individual IWPUT for the proposed work values:

IWPUT Calculator				

33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)			
Building Block Method			**RVW**	**-62 Mod RVW**
Proposed RVW			**40.00**	**25.00**
Pre-service	**Time**	**Intensity**	**-62 Mod Intensity**	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
Pre-service total				**1.01**
Post-service	**Time**	**Intensity**	**-62 Mod Intensity**	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	**Visit n**	**E/M RVU**	**-62 ModE/M RVU**	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
Post-service total				**3.44**
	Time		**IWPUT**	
Intra-service	195		**0.1054**	**20.54625**

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the current MPC list.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency on the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery.
The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0257 T Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular) and 0258T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass

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

Specialty Cardiology and Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1190
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovasular approaches (3300) 33361 ercutaneous 30%, 33362 femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery Frequency 1190 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,130
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery Frequency 1130 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33367 Tracking Number GG7 Original Specialty Recommended RVU: **11.88**
Presented Recommended RVU: **11.88**
Global Period: ZZZ RUC Recommended RVU: **11.88**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)
(Use 33367 in conjunction with 33361-33366)
(Do not report 33367 in conjunction with 33368 or 33369)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. Note: This is an add-on service to the TAVR/TAVI which is reported separately.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A patient undergoing TAVR becomes hemodynamically unstable, and cannot be stabilized with inotropic support or any standard medical means. The patient is anticoagulated. The artery and vein are cannulated with sheaths using direct percutaneous access. Guidewires are advanced into the distal abdominal aorta and into the superior vena cava. Dilators are employed to ultimately place a sufficient sized arterial cannula and a multiply ported venous drainage cannula across the right atrium into the superior vena cava. The cannulas are de-aired and connected to a cardiopulmonary bypass circuit. Cardiopulmonary bypass is initiated. Cardiopulmonary bypass with its attendant volume shifts and the activation of the inflammatory system is managed with volume replacement and alpha effector agents. Anticoagulation is maintained. Management continues while the TAVR procedure is completed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are normalized and the patient is weaned from cardiopulmonary bypass. Anticoagulation is reversed. The cannulas are removed percutaneously. Hemostasis is achieved through percutaneous closure devices or, if necessary, open vascular repair (reported separately).

CPT Code: 33367

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	33367		
Sample Size:	70	**Resp N:** 35	**Response:** 50.0 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	5.00	28.00
Survey RVW:	5.00	11.88	**16.67**	26.20	100.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	45.00	**90.00**	180.00	360.00

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

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

Specialty Society Recommended Data

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

CPT Code:	33367	**Recommended Physician Work RVU: 11.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**90.00**		

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

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37223	ZZZ	4.25	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

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

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

CPT Descriptor 1 see separate MPC table for TAVR codes

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33960	ZZZ	10.59	**RUC Time**

CPT Descriptor Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours
*CPT code is a 000 day global that was adjusted in work and time to represent a ZZZ global per approval from the research subcommittee and the adjusted time data was used on the RSL.

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33367**	**Key Reference CPT Code:** 37223	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	90.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**90.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.29	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.71
Urgency of medical decision making	4.57	3.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.00
Physical effort required	3.43	3.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.57	3.43
Outcome depends on the skill and judgment of physician	4.71	3.43
Estimated risk of malpractice suit with poor outcome	4.29	3.43

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.29	3.14
Intra-Service intensity/complexity	3.71	3.57
Post-Service intensity/complexity	4.00	3.14

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were the cardiac surgeon members of teams of co-operators who participated in clinical trials of these new devices.

They evaluated the three add-on, ZZZ codes to report when cardiopulmonary bypass is necessary for the procedure (**33367**, **33368**, **33369**).

The three bypass codes represent different approaches for accomplishing bypass if it becomes necessary during the procedure. The majority of TAVR cases that require bypass will involve an emergent situation that occurs during the procedure due to aortic insufficiency or the patient's inability to withstand rapid pacing or balloon valvuloplasty. There will be a small percentage of cases where bypass is planned as part of the procedure and it will only be applicable to a specific patient population and will not be typical.

The three cardiopulmonary bypass codes were surveyed specifically as they relate to the TAVR procedures. Bypass related to TAVR is not equivalent to any of the existing "with or without" bypass procedure. In addition, the typical TAVR patient is 83 years old with multiple comorbidities, adding to the complexity of the procedure.

The Expert Panel reviewed the survey results and recommends that the 25th percentile RVWs for these codes accurately represents the work involved and results in an appropriate IWPUT (0.132) for this service. This intensity is well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including several codes from the current MPC list. This intensity is frequently observed in add-on codes, and accurately reflects the significant urgent decision making which must be made to select appropriate vascular access sites and accomplish the technical aspects of the procedure in patients with significant diffuse vascular disease. Management of cardiopulmonary bypass and the inherent bleeding risk and inflammatory while continuing the valve replacement procedure adds significant work to the base procedure.

In the context of the entire presentation of **33361**-**33369**, it is important to note that the -62 modifier would not be appended to the codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

scenario. Code 33367 will be reported in conjunction with one of the new codes 33361- 33366 when applicable.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0259T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass

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

Specialty Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, of that number it is estimated that approximately 5% will require emergent cardiopulmonary bypas support. There are three bypass codes and it is estimated that the 33367 percutaneouls peripheraial approach will be utilized 30% of the time, that 33368 open peripherial approach will be utilized 30% of the time and that 33369 central access will be used 40% of the time.

Specialty Cardiovascular Surgery Frequency 75 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 71 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiovascular Surgery Frequency 71 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33368 Tracking Number GG8 Original Specialty Recommended RVU: **14.39**
Presented Recommended RVU: **14.39**
Global Period: ZZZ RUC Recommended RVU: **14.39**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)
(Use 33368 in conjunction with 33361-33366)
(Do not report 33368 in conjunction with 33367 or 33369)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. However, the femoral vessels are not suitable for percutaneous cannulation, therefore an open approach is utilized. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. Note: This is an add-on service to the TAVR/TAVI which is reported separately.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A patient undergoing TAVR becomes hemodynamically unstable, and cannot be stabilized with inotropic support or any standard medical means. The patient is anticoagulated. A new incision is made and the artery and vein are exposed and controlled with vessel loops. The artery is clamped and a transverse arteriotomy performed. A suitably sized arterial cannula is advanced over a guidewire. A pursestring polypropylene suture is place in the vein, and a guidewire inserted through a needle placed within it and advanced into the vena cava under fluoroscopic guidance. A multiply ported venous drainage cannula is passed over the guidewire, across the right atrium and into the vena cava. The cannulas are de-aired and connected to a cardiopulmonary bypass circuit. Cardiopulmonary bypass is initiated. Cardiopulmonary bypass with its attendant volume shifts and the activation of the inflammatory system is managed with volume replacement and alpha effector agents. Anticoagulation is maintained. Management continues while the TAVR procedure is completed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are

normalized and the patient is weaned from cardiopulmonary bypass. The venous cannula is removed and bleeding controlled by tying the previously placed pursestring. The arterial cannula is removed and the arteriotomy is repaired with 6-0 polypropylene sutures. Anticoagulation is reversed, and after assuring hemostasis the wound is closed in layers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	33368		
Sample Size:	70	**Resp N:** 34	**Response:** 48.5 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	125.00
Survey RVW:	8.25	14.39	**20.00**	28.63	110.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	74.00	**120.00**	180.00	400.00

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

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

Specialty Society Recommended Data

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

CPT Code:	33368	**Recommended Physician Work RVU: 14.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**120.00**		

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

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33960	ZZZ	10.59	**RUC Time**

CPT Descriptor Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day
*code value was adjusted to ZZZ global from 000 day global for RSL which was approved by the Research Subcommittee

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

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

CPT Descriptor 1 see separate MPC table for TAVR codes

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33426	ZZZ	22.75	**RUC Time**

CPT Descriptor Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring
*code value was adjusted to ZZZ global from 090 day global for RSL which was approved by the Research Subcommittee

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 33368**	**Key Reference CPT Code:** 33960	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	120.00	133.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**120.00**	**133.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	4.14
Urgency of medical decision making	4.71	4.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.14
Physical effort required	4.00	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.71	4.29
Outcome depends on the skill and judgment of physician	4.57	4.29
Estimated risk of malpractice suit with poor outcome	4.00	3.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.57
Intra-Service intensity/complexity	4.43	4.00
Post-Service intensity/complexity	4.14	4.43

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally

consistent. All survey respondents were the cardiac surgeon members of teams of co-operators who participated in clinical trials of these new devices.

They evaluated the three add-on, ZZZ codes to report when cardiopulmonary bypass is necessary for the procedure (33367, 33368, 33369).

The three bypass codes represent different approaches for accomplishing bypass if it becomes necessary during the procedure. The majority of TAVR cases that require bypass will involve an emergent situation that occurs during the procedure due to aortic insufficiency or the patient's inability to withstand rapid pacing or balloon valvuloplasty. There will be a small percentage of cases where bypass is planned as part of the procedure and it will only be applicable to a specific patient population and will not be typical.

The three cardiopulmonary bypass codes were surveyed specifically as they relate to the TAVR procedures. Bypass related to TAVR is not equivalent to any of the existing "with or without" bypass procedure. In addition, the typical TAVR patient is 83 years old with multiple comorbidities, adding to the complexity of the procedure.

The Expert Panel reviewed the survey results and recommends that the 25th percentile RVWs for these codes accurately represents the work involved and results in an appropriate IWPUT (0.120) for this service. This intensity is well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including several codes from the current MPC list. This intensity is frequently observed in add-on codes, and accurately reflects the significant urgent decision making which must be made to select appropriate vascular access sites and accomplish the technical aspects of the procedure in patients with significant diffuse vascular disease. Management of cardiopulmonary bypass and the inherent increased bleeding and inflammatory response as well as operative repair of the cannulation sites (not billed separately) adds significant work to the base procedure.

In the context of the entire presentation of 33361-33369, it is important to note that the -62 modifier would not be appended to the codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 33368 will be reported in conjunction with one of the new codes 33361-33367 when applicable

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FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0259T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass

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

Specialty Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, of that number it is estimated that approximately 5% will require emergent cardiopulmonary bypas support. There are three bypass codes and it is estimated that the 33367 percutaneouls peripheraial approach will be utilized 30% of the time, that 33368 open peripherial approach will be utilized 30% of the time and that 33369 central access will be used 40% of the time.

Specialty Cardiovascular Surgery Frequency 75 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 71 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiovascular Surgery Frequency 71 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33369 Tracking Number GG9 Original Specialty Recommended RVU: **19.00**
Presented Recommended RVU: **19.00**
Global Period: ZZZ RUC Recommended RVU: **19.00**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)
(Use 33369 in conjunction with 33361-33366)
(Do not report 33369 in conjunction with 33367 or 33368)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. However, because of severe aortoiliac disease, central arterial and venous access is required for institution of safe cardiopulmonary bypass. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. Note: This is an add-on service to the TAVR/TAVI which is reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A patient undergoing TAVR becomes hemodynamically unstable, and cannot be stabilized with inotropic support or any standard medical means. The patient is anticoagulated. If not already achieved by the TAVR approach, exposure of the great vessels is obtained by rapid median sternotomy and the creation of a pericardial well. The aorta is directly cannulated for arterial inflow and a dual stage venous return cannula is placed through a right atrial incision. Cardiopulmonary bypass is initiated. Pursestrings are then placed about both cannulae and they are secured. Cardiopulmonary bypass with its attendant volume shifts and the activation of the inflammatory system is managed with volume replacement and alpha effector agents. Anticoagulation is maintained. Management continues while the TAVR procedure is completed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are normalized and the patient is weaned from cardiopulmonary bypass. Anticoagulation is reversed, the cannulae removed and hemostasis is achieved by tying the previously placed pursestring sutures. Additional sutures may be required. After assuring

hemostasis, the sternum is reapproximated with stainless steel wires over mediastinal drains. The wound is then irrigated and closed in layers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	33369		
Sample Size:	70	**Resp N:** 35	**Response:** 50.0 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	5.00	100.00
Survey RVW:	10.00	19.00	**27.95**	32.88	120.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	90.00	**160.00**	240.00	420.00

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

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

Specialty Society Recommended Data

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

CPT Code:	33369	**Recommended Physician Work RVU: 19.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**160.00**		

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

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service?

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33305	ZZZ	29.60	**RUC Time**

CPT Descriptor Repair of cardiac wound; with cardiopulmonary bypass
*code value was adjusted to ZZZ global from 0900 day global for RSL which was approved by the Research Subcommittee

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

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

CPT Descriptor 1 see separate MPC table for TAVR codes

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33530	ZZZ	8.08	**RUC Time**

CPT Descriptor Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 42.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 33369**	**Key Reference CPT Code:** 33305	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	160.00	296.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**160.00**	**296.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.87	4.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.87	4.27
Urgency of medical decision making	4.73	4.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.87	4.80
Physical effort required	4.47	4.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.87	4.33
Outcome depends on the skill and judgment of physician	4.73	4.33
Estimated risk of malpractice suit with poor outcome	4.20	3.87

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.80	4.40
Intra-Service intensity/complexity	4.87	4.33
Post-Service intensity/complexity	4.80	4.20

Additional Rationale and Comments

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

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and

finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were the cardiac surgeon members of teams of co-operators who participated in clinical trials of these new devices.

They evaluated the three add-on, ZZZ codes to report when cardiopulmonary bypass is necessary for the procedure (33367, 33368, 33369).

The three bypass codes represent different approaches for accomplishing bypass if it becomes necessary during the procedure. The majority of TAVR cases that require bypass will involve an emergent situation that occurs during the procedure due to aortic insufficiency or the patient's inability to withstand rapid pacing or balloon valvuloplasty. There will be a small percentage of cases where bypass is planned as part of the procedure and it will only be applicable to a specific patient population and will not be typical.

The three cardiopulmonary bypass codes were surveyed specifically as they relate to the TAVR procedures. Bypass related to TAVR is not equivalent to any of the existing "with or without" bypass procedure. In addition, the typical TAVR patient is 83 years old with multiple comorbidities, adding to the complexity of the procedure.

The Expert Panel reviewed the survey results and recommends that the 25th percentile RVWs for these codes accurately represents the work involved and results in an appropriate IWPUT (0.119) for this service. This intensity is well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including several codes from the current MPC list. This intensity is frequently observed in add-on codes, and accurately reflects the significant urgent decision making which must be made to select appropriate vascular access sites and accomplish the technical aspects of the procedure in patients with significant diffuse vascular disease. Management of cardiopulmonary bypass and the inherent increased bleeding and inflammatory response as well as operative repair of the cannulation sites (not billed separately) adds significant work to the base procedure.

In the context of the entire presentation of 33361-33369, it is important to note that the -62 modifier would not be appended to the codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 33369 will be reported in conjunction with one of the new codes 33361-33366 when applicable

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FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0259T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass

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

Specialty Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, of that number it is estimated that approximately 5% will require emergent cardiopulmonary bypas support. There are three bypass codes and it is estimated that the 33367 percutaneouls peripheraial approach will be utilized 30% of the time, that 33368 open peripherial approach will be utilized 30% of the time and that 33369 central access will be used 40% of the time.

Specialty Cardiovascular Surgery Frequency 100 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 95 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiovascular Surgery Frequency 95 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33305

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
11	**ISSUE:**	**Transcatheter Aortic Valve Replcement**																									
12	**TAB:**	**12**																									
13	**000 Day Global codes**																										
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39
16	REF	33880	Endovascular repair of	14	0.096			27.21			455	90	20	20			225			45	1						
18	SVY	33361	Transcatheter aortic valve replacement	33	0.165	6.74	25.13	29.50	35.00	50.00	345	45	20	30	30	120	135	180	300	45	1					
19	REC	33361	Transcatheter aortic valve replacement		0.166	29.50					335	50	15	20			135			45	1						
20	62 modifier	33361	Transcatheter aortic valve replacement		0.104	18.44					335	50	15	20			135			45	1						
21																											
22	REF	33880	Endovascular repair of	19	0.096			27.21			455	90	20	20			225			45	1						
24	SVY	33362	open femoral artery approach	38	0.165	11.34	27.52	32.00	35.59	54.00	360	45	20	30	30	120	150	195	300	45	1					
25	REC	33362	open femoral artery approach		0.166	32.00					350	50	15	20			150			45	1						
26	62 modifier	33362	open femoral artery approach		0.104	20.00					350	50	15	20			150			45	1						
27																											
28	REF	33880	Endovascular repair of	13	0.096			27.21			455	90	20	20			225			45	1						
30	SVY- 0 performance	33363	open axillary artery approach	17	0.132	11.34	28.13	31.50	39.25	58.00	415	60	30	30	120	135	180	195	330	45	1					
31	SVY >0 performance	33363	open axillary artery approach	16	0.151	22.21	29.25	33.50	37.50	51.11	391	53	20	30	70	135	173	240	250	45	1					
32	SVY- Aggregate	33363	open axillary artery approach	33	0.139	11.34	28.50	33.00	37.50	58.00	423	60	30	30	70	130	180	200	330	53	1					
33	REC	33363	open axillary artery approach		0.144	33.00					380	50	15	20			180			45	1						
34	62 modifier	33363	open axillary artery approach		0.090	20.63					380	50	15	20			180			45	1						

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39
35																											
36	REF	33880	Endovascular repair of	15	0.096			27.21			455	90	20	20			225			45	1						
38	SVY	33364	open iliac artery approach	31	0.152	8.80	30.00	34.87	39.74	65.00	403	53	25	30	70	150	180	240	330	45	1						
39	REC	33364	open iliac artery approach		0.154			34.87			380	50	15	20			180			45	1						
40	62 modifier	33364	open iliac artery approach		0.096			21.79			380	50	15	20			180			45	1						
41																											
42	REF	33979	Insertion of ventricular assist	15	0.117			37.50			495	60	20	15			280			120							
44	SVY	33365	transaortic approach (eg,	30	0.165	10.50	30.00	37.50	40.00	56.00	415	60	30	30	45	175	180	210	340	45	1						
45	REC	33365	transaortic approach (eg,		0.169			37.50			380	50	15	20			180			45	1						
46	62 modifier	33365	transaortic approach (eg,		0.105			23.44			380	50	15	20			180			45	1						
47																											
48	REF	33979	Insertion of ventricular assist	18	0.117			37.50			495	60	20	15			280			120							
50	SVY- 0 performance	33366	transapical approach (eg, left	19	0.192	27.21	37.50	42.00	45.06	56.00	403	53	25	30	100	148	180	213	320	45	1						
51	SVY >0 performance	33366	transapical approach (eg, left	12	0.125	22.21	28.91	33.00	37.75	46.75	443	60	30	30	75	180	200	250	340	53	1						
52	SVY- Aggregate	33366	transapical approach (eg, left	31	0.165	22.21	32.00	40.00	43.13	56.00	430	60	30	30	75	173	195	225	340	45	1						
53	REC	33366	transapical approach (eg, left		0.169			40.00			395	50	15	20			195			45	1						
54	62 modifier	33366	transapical approach (eg, left		0.105			25.00			395	50	15	20			195			45	1						
55	Reference code RVW and times have been adjusted to represent 000 day global procedures as used in RSL for survey and approved by Research Subcommittee																										

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39
56																											
57	ZZZ Day Global codes																										
58	REF	37223	Revascularization, endovascular, open	7	0.094			4.21			45						45										
60	SVY	33367	Transcatheter aortic valve replacement	35	0.185	5.00	11.88	16.67	26.20	100.00	90				3	45	90	180	360							
61	REC	33367	Transcatheter aortic valve replacement		0.132			11.88			90						90										
62																											
63	REF	33960	Prolonged extracorporeal	7	0.080			10.59			133						133										
65	SVY	33368	cardiopulmonary bypass support	34	0.167	8.25	14.39	20.00	28.63	110.00	120				4	74	120	180	400							
66	REC	33368	cardiopulmonary bypass support		0.120			14.39			120						120										
67																											
68	REF	33305	Repair of cardiac wound; with	15	0.100			29.60			296						296										
70	SVY	33369	cardiopulmonary bypass support	35	0.175	10.00	19.00	27.95	32.88	120.00	160				5	90	160	240	420							
71	REC	33369	cardiopulmonary bypass support		0.119			19.00			160						160										
72	Reference code RVW and times have been adjusted to represent ZZZ global procedures as used in RSL for survey and approved by Research Subcommittee																										
73																											
74																											

glob day	CPT code	MPC	Predominant Specialty	Long Descriptor	IWPUT with -62 Modifier	2012 IWPUT	Work RVU with -62 Modifier Per Physician	000 Work RVU	000 Time	2012 Work RVU	RUC Year	Medicare Freq 2010	2012 nonfac pe rvu	2012 fac pe rvu	2012 mp rvu	glob day	Dress scrub and wait time	pres service eval time	intra service time	other preop time (positioning)	op icu time after surg	same day post op time (immd post same day	Office Visits time	post op hosp time	Total time
090	35587	No	Vascular surgery	In-situ vein bypass; popliteal-tibial, peroneal		0.085		19.47	343	26.21	2000	253	10.71	10.71	6.04	090	0	93	180	0	0	30	62	158	523
090	49525	No	General Surgery	Repair inguinal hernia, sliding, any age		0.086		6.84	135	8.93	2000	2,166	5.91	5.91	1.86	090	0	45	60	0	0	30	39	19	193
090	92990	No	Cardiology	Percutaneous balloon valvuloplasty; pulmonary valve		0.087		15.36	324	18.27	2002	40	10.57	10.57	3.99	090	0	79	126	0	0	119	69	0	393
000	37225	No	no data	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed		0.087		12.00	196	12.00	2010		316.59	4.18	2.52	000	5	40	118	3	0	30	0	0	196
010	36561	No	General Surgery	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older		0.088		4.92	95	6.04	2003	120,604	28.46	3.47	1.10	010	10	20	45	5	0	15	16	19	130
090	47562	Yes	General Surgery	Laparoscopy, surgical; cholecystectomy		0.088		8.70	165	11.76	2005	116,094	7.61	7.61	2.48	090	15	30	80	15	0	25	62	19	246
000	36246	No	Cardiology	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family		0.088		5.27	106	5.27	2011	62,692	24.28	1.95	0.98	000	5	33	45	3	0	20	0	0	106
090	32663	No	Cardiothoracic Surgery	Thoracoscopy, surgical; with lobectomy (single lobe)		0.088		17.76	315	24.64	2011	4,969	11.90	11.90	5.74	090	20	40	155	15	0	30	39	208	507
090	46262	For X3	General Surgery	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed		0.089		5.34		7.91	2000	230	6.72	6.72	1.44	090	0	40	45	0	0	20	55	19	179
XXX	99284	Yes	Emergency Medicine	Emergency department visit for the evaluation and management of a patient,		0.089		2.56	40	2.56	2005	5,555,818	0.59	0.59	0.22	XXX	0	5	25	0	0	10	0	0	40
090	35654	Yes	Vascular surgery	Bypass graft, with other than vein; axillary-femoral-femoral		0.089		20.16	340	26.28	2000	875	10.44	10.44	6.07	090	0	90	180	0	0	30	55	158	513
	33363		Cardiovascular Surgery and Cardiology	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	0.090	0.090	20.63	33.00	380	33.00	Specialty Recommendations					20	50	180	15		45			380
090	14060	Yes	Dermatology	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less		0.090		6.33	105	9.23	2008	96,958	12.34	9.50	1.42	090	5	15	60	10	0	15	78	0	183
090	33140	No	Cardiothoracic Surgery	Transmyocardial laser revascularization, by thoracotomy; (separate procedure)		0.090		17.41	318	28.34	2005	52	12.66	12.66	7.08	090	20	60	113	15	70	40	40	263	621
090	49560	Yes	General Surgery	Repair initial incisional or ventral hernia; reducible		0.091		9.83	165	11.92	2000	32,414	7.09	7.09	2.48	090	0	45	90	0	0	30	39	19	223
000	57460	No	Obstetrics/ Gynecology	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix		0.091		2.83	50	2.83	2002	1,275	5.27	1.57	0.48	000	0	15	25	0	0	10	0	0	50
090	34825	No	Vascular surgery	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel		0.091		9.31	210	12.80	2002	12,037	6.07	6.07	2.75	090	0	80	60	0	0	30	39	98	307
090	29806	No	Orthopedic surgery	Arthroscopy, shoulder, surgical; capsulorrhaphy		0.092		11.12	185	15.14	2002	1,687	13.13	13.13	2.98	090	0	55	100	0	0	30	94	19	298
000	52315	No	Urology	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated		0.093		5.20	94	5.20	2010	4,800	6.78	2.44	0.50	000	5	19	45	5	0	20	0	0	94
000	93458	No	no data	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when		0.093		5.85	123	5.85	2010		25.08	25.08	1.33	000	5	40	45	3	0	30	0	0	123

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090	58573	No	Obstetrics/ Gynecology	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)		0.093		18.65	295	23.11	2007	523	12.40	12.40	3.89	090	5	45	165	10	0	30	62	98	415
000	20660	No	Neurosurgery	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)		0.093		4.00	90	4.00	2007	3,499	2.06	2.06	1.10	000	10	20	30	0	0	30	0	0	90
090	19301	No	General Surgery	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);		0.093		7.07	135	10.13	2007	40,140	6.53	6.53	2.15	090	15	30	60	10	0	20	62	19	216
000	43269	No	Gastroenterology	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent		0.093		8.20	141	8.20	2000	19,975	4.73	4.73	1.21	000	0	40	71	0	0	30	0	0	141
090	38745	No	General Surgery	Axillary lymphadenectomy; complete		0.094		10.28	173	13.87	2000	3,264	8.66	8.66	2.95	090	0	57.5	90	0	0	25	79	19	270
000	51102	Yes	Urology	Aspiration of bladder; with insertion of suprapubic catheter		0.094		2.70	60	2.70	2008	13,947	3.82	1.35	0.29	000	5	19	20	1	0	15	0	0	60
000	93455	No	no data	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography		0.094		5.54	123	5.54	2010		24.42	24.42	1.25	000	5	45	40	3	0	30	0	0	123
090	57287	No	Urology	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)		0.094		7.12	135	11.15	2010	2,127	7.61	7.61	1.47	090	15	33	60	7	0	20	85	19	239
XXX	99291	Yes	Emergency Medicine	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes		0.096		4.50	70	4.50	2005	4,752,537	3.01	1.54	0.34	XXX	0	15	40	0	0	15	0	0	70
000	93459	No	no data	Catheter placement in coronary artery(s) for coronary angiography,		0.096		6.60	133	6.60	2010		27.55	27.55	1.47	000	5	45	50	3	0	30	0	0	133
	33364		Cardiovascular Surgery and Cardiology	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	0.096	0.096	21.79	34.87	380	34.87	Specialty Recommendations					20	50	180	15		45			380
090	44204	Yes	General Surgery	Laparoscopy, surgical; colectomy, partial, with anastomosis		0.097		20.44	295	26.42	2002	11,314	13.41	13.41	5.23	090	0	45	180	0	0	30	62	138	455
000	19103	Yes	Diagnostic Radiology	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance		0.097		3.69	65	3.69	2000	108,200	11.94	1.40	0.48	000	0	20	30	0	0	15	0	0	65
090	33510	No	Cardiothoracic Surgery	Coronary artery bypass, vein only; single coronary venous graft		0.097		22.18	359	34.98	2005	6,242	15.80	15.80	8.41	090	20	60	154	15	70	40	56	303	718
010	22524	No	Neurosurgery	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar		0.097		6.93	135	8.54	2010	24,197	213.19	5.73	1.68	010	15	30	55	15	0	20	23	19	177
090	58292	No	Obstetrics/Gynecology	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele		0.097		18.74	299	23.35	2002	27	12.01	12.01	3.93	090	0	75	154	0	0	30	46	118	423
000	34812	Yes	Vascular surgery	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral		0.098		6.74	150	6.74	2002	32,150	2.12	2.12	1.55	000	0	75	45	0	0	30	0	0	150
090	19303	Yes	General Surgery	Mastectomy, simple, complete		0.098		10.37	170	15.85	2005	21,917	9.91	9.91	3.38	090	15	30	90	15	0	20	86	58	314
090	27447	No	Orthopedic surgery	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)		0.099		15.77	269	23.25	2005	270,073	17.55	17.55	4.57	090	15	45	124	15	0	30	102	138	469

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000	32550	No	Cardiothoracic Surgery	Insertion of indwelling tunneled pleural catheter with cuff		0.099		4.17	90	4.17	2004	8,135	18.77	1.82	0.69	000	10	15	30	15	0	20	0	0	90
090	34802	Yes	Vascular surgery	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)		0.100		20.30	365	23.79	2000	12,731	9.70	9.70	5.09	090	0	135	150	0	0	40	39	98	462
000	31276	No	Otolaryngology	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus		0.100		8.84	135	8.84	2010	18,664	5.14	5.14	1.14	000	0	30	75	0	0	30	0	0	135
090	34805	No	Vascular surgery	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis		0.101		19.18	325	22.67	2003	644	9.18	9.18	5.04	090	25	65	150	15	0	30	39	98	422
000	93453	No	no data	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed		0.101		6.24	123	6.24	2010		26.30	26.30	1.41	000	5	40	45	3	0	30	0	0	123
000	49452	No	Diagnostic Radiology	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report		0.102		2.86	60	2.86	2007	7,907	23.56	1.07	0.27	000	5	20	20	5	0	10	0	0	60
090	33475	No	Cardiothoracic Surgery	Replacement, pulmonary valve		0.102		31.11	439	42.40	2005	89	18.23	18.23	10.60	090	20	60	234	15	70	40	63	248	750
000	93452	No	no data	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed		0.102		4.75	108	4.75	2010		20.09	20.09	1.09	000	5	40	30	3	0	30	0	0	108
090	43772	No	General Surgery	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only		0.103		12.97	240	15.70	2005	101	8.83	8.83	3.36	090	10	45	90	25	0	30	39	78	317
090	33512	Yes	Cardiothoracic Surgery	Coronary artery bypass, vein only; 3 coronary venous grafts		0.103		29.18		43.98	2005	2,970	19.17	19.17	10.60	090	20	60	213	15	70	40	56	358	832
090	44188	No	General Surgery	Laparoscopy, surgical, colostomy or skin level cecostomy		0.103		13.01	240	19.35	2005	1,825	12.67	12.67	3.84	090	10	45	90	25	0	30	69	138	407
	33361		Cardiovascular Surgery and Cardiology	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	0.104	0.104	18.44	29.50	335	29.50	Specialty Recommendations					20	50	135	15		45			335
	33362		Cardiovascular Surgery and Cardiology	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	0.104	0.104	20.00	32.00	350	32.00	Specialty Recommendations					20	50	150	15		45			350
000	31629	No	Pulmonary Disease	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)		0.104		4.09	80	4.09	2003	17,970	13.82	1.59	0.34	000	10	10	30	10	0	20	0	0	80
000	93454	No	no data	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;		0.104		4.79	108	4.79	2010		20.85	20.85	1.09	000	5	40	30	3	0	30	0	0	108
000	52276	Yes	Urology	Cystourethroscopy with direct vision internal urethrotomy		0.104		4.99		4.99	1995	11,473	2.41	2.41	0.49	000	0	30	35	0	0	30	0	0	95
090	44187	No	General Surgery	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube		0.105		11.55	225	17.40	2005	516	11.68	11.68	3.31	090	10	45	75	25	0	30	62	138	385

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090	33880	No	Vascular surgery	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin		0.105		29.21	455	34.58	2005	673	13.15	13.15	7.72	090	20	90	225	20	0	45	46	153	599
	33366		Cardiovascular Surgery and Cardiology	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)	0.105	0.105	25.00	40.00	395	40.00	Specialty Recommendations					20	50	195	15		45			395
	33365		Cardiovascular Surgery and Cardiology	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	0.105	0.105	23.44	37.50	380	37.50	Specialty Recommendations					20	50	180	15		45			380
090	33255	No	Cardiothoracic Surgery	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass		0.106		23.14	355	29.04	2006	87	13.79	13.79	7.25	090	20	60	180	15	0	40	63	138	516
090	22554	Yes	Neurosurgery	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2		0.106		13.50	255	17.69	2010	34,259	14.58	14.58	5.47	090	15	60	90	20	0	30	69	78	362
090	33315	No	Cardiothoracic Surgery	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass		0.106		26.07	373	35.00	2010	275	14.30	14.30	8.41	090	20	40	180	3	70	60	40	208	621
090	49520	No	General Surgery	Repair recurrent inguinal hernia, any age; reducible		0.106		7.90	128	9.99	2000	8,951	6.32	6.32	2.10	090	0	45	60	0	0	22.5	39	19	186
090	34800	No	Vascular surgery	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis		0.107		18.05	330	21.54	2000	486	8.79	8.79	4.57	090	0	130	120	0	0	40	39	98	427
090	33883	No	Vascular surgery	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension		0.107		17.11	300	21.09	2005	470	8.81	8.81	4.70	090	20	70	120	20	0	30	46	98	404
XXX	61635	No	Diagnostic Radiology	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed		0.107		19.67	300	24.28	2005	457	12.23	12.23	4.07	XXX	20	30	150	15	0	45	46	118	424
XXX	33981	No	Cardiothoracic Surgery	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump		0.108		16.11	275	16.11	2010	7	5.26	5.26	4.02	XXX	20	60	120	15	0	60	0	0	275
000	37220	No	no data	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty		0.108		8.15	138	8.15	2010		87.12	2.75	1.67	000	5	40	60	3	0	30	0	0	138
090	57288	No	Obstetrics/Gynecology	Sling operation for stress incontinence (eg, fascia or synthetic)		0.108		8.10	142	12.13	2010	47,685	7.44	7.44	1.59	090	15	33	60	7	0	27	85	19	246
090	43770	No	General Surgery	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)		0.108		13.81	260	18.00	2005	5,008	10.82	10.82	3.81	090	15	60	90	25	0	30	69	78	367
090	29916	No	no data	Arthroscopy, hip, surgical; with labral repair		0.108		11.46	173	15.00	2010		12.68	12.68	2.95	090	10	33	90	20	0	20	78	19	270
090	59150	No	Obstetrics/ Gynecology	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy		0.110		9.71	160	12.29	2000	26	7.32	7.32	3.54	090	0	60	70	0	0	30	46	19	225

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090	33426	Yes	Cardiothoracic Surgery	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring		0.111		29.99	410	43.28	2005	6,246	19.03	19.03	10.41	090	20	60	205	15	70	40	63	303	776
090	92986	No	Cardiology	Percutaneous balloon valvuloplasty; aortic valve		0.112		17.90	346	22.85	2002	2,744	12.91	12.91	4.98	090	0	98	113	0	0	135	69	58	473
090	37660	No	Vascular surgery	Ligation of common iliac vein		0.112		17.40	260	22.28	2000	37	11.34	11.34	4.75	090	0	60	120	0	0	25	39	153	397
090	33410	No	Cardiothoracic Surgery	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve		0.113		33.12	434	46.41	2005	1,302	19.83	19.83	11.15	090	20	60	229	15	70	40	63	303	800
000	93460	No	no data	Catheter placement in coronary artery(s) for coronary angiography,		0.113		7.35	128	7.35	2010		29.10	29.10	1.63	000	5	40	50	3	0	30	0	0	128
090	33406	No	Cardiothoracic Surgery	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)		0.114		39.39	487	52.68	2005	432	22.07	22.07	12.77	090	20	60	282	15	70	40	63	303	853
000	31600	Yes	General Surgery	Tracheostomy, planned (separate procedure);		0.114		7.17	156	7.17	2000	37,809	3.37	3.37	1.27	000	0	50	40	0	0	66	0	0	156
000	52346	No	Urology	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)		0.116		8.58	140	8.58	2010	114	4.19	4.19	0.83	000	10	40	60	10	0	20	0	0	140

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ZZZ	63295	Yes	Neurosurgery	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	0.112	5.03	45	5.25	2004	40	0	10	45	0	0	0	0	55
000	31600	Yes	General Surgery	Tracheostomy, planned (separate procedure);	0.114	4.57	40	7.17	2000	37,809	0	50	40	0	66	0	0	156
ZZZ	61797	No	Neurosurgery	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)	0.116	3.48	30	3.48	2008	3,509	0	0	30	0	0	0	0	30
XXX	33982	No	Cardiothoracic Surgery	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	0.117	34.00	290	37.86	2010	3	20	60	290	15	90	0	0	475
ZZZ	33369		Cardiovascular Surgery	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary	0.119	19.00	160	19.00	Specialty Recommendations				160					160
000	36556	Yes	Anesthesiology	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	0.119	1.79	15	2.50	2003	516,697	5	15	15	5	10	0	0	50
000	37191	No	no data	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	0.120	3.59	30	4.71	2011	no data	5	30	30	3	15	0	0	83
ZZZ	33368		Cardiovascular Surgery	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)	0.120	14.39	120	14.39	Specialty Recommendations				120					120
000	52344	No	Urology	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg,	0.120	5.40	45	7.05	2010	2,654	10	40	45	10	20	0	0	125
ZZZ	35600	Yes	Cardiac Surgery	Harvest of upper extremity artery, 1 segment, for coronary artery bypass	0.124	4.94	40	4.94	2000	2,373	0	0	40	0	0	0	0	40
000	93581	No	Cardiology	Percutaneous transcatheter closure of a congenital ventricular septal defect	0.124	22.37	180	24.39	2002	55	0	30	180	0	60	0	0	270
000	16035	No	Podiatry	Escharotomy; initial incision	0.131	2.62	20	3.74	2000	636	0	30	20	0	20	0	0	70

glob day	CPT code	MPC	Predominant Specialty	Long Descriptor	2012 IWPUT	ZZZ Work RVU	ZZZ Time	2012 Work RVU	RUC Year	Medicare Freq 2010	Dress scrub and wait time	pre service eval time	intra service time	other preop time (positioning)	same day post op time (immd post same day	Office Visits time	post op hosp time	Total time
ZZZ	33367		Cardiovascular Surgery	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)	0.132	11.88	90	11.88	Specialty Recommendations				90					90
ZZZ	33884	No	Vascular surgery	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	0.137	8.20	60	8.20	2005	125	0	0	60	0	0	0	0	60

CPT Code: 33361 – 33366
Specialty Society('s): ACC/ STS/ SCAI

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

CPT Long Descriptor:

33361 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362 - open femoral artery approach
33363 - open axillary artery approach
33364 - open iliac artery approach
33365 - transaortic approach (eg, median sternotomy, mediastinotomy)
33366 - transapical approach (eg, left thoracotomy)

Global Period: 000 Meeting Date: April 2012

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

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Codes 33980 - Removal of ventricular assist device, implantable intracorporeal, single ventricle
This code represents an XXX global procedure that was reviewed by the RUC and the Practice Expense Subcommittee at the February of 2011 RUC meeting. 33980 is a procedure that is performed in the facility setting 100% of the time and requires office staff time that would be typical of a 90-day global procedure performed in the facility setting. This code has an approved pre-facility clinical staff time of 60 minutes. Since cardiothoracic offices typically employ PAs, the cardiothoracic codes are typically assigned CMS code L051A and staff type RN.

The TAVR codes also represent procedures that will be performed in the facility 100% of the time and will require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The main difference between the TAVR codes and the reference code is that the TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment. Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather then the RN staff type typical to the cardiothoracic surgery codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff from both offices fill out the pre-service diagnostic and referral forms. They call the hospital

to schedule space and equipment needed in the facility. They will also coordinate with specialized anesthesiologist, the perfusionist, radiology and any other physician offices to set up the case. The clinical staff will also coordinate with the hospital to schedule the OR and the specialized equipment for the procedure. The operating room coordinating requires ensuring the needed hybrid equipment including the catheter-based equipment for the valve deployment, any instrumentation needed for an open approach or conversion to an open approach and cardiopulmonary bypass equipment as well as supporting imaging equipment for the procedure. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understands the procedure and the recovery afterwards and obtains the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

	A	B	C	D	E	F	G	H	I	J
1				Reference Code						
2				**33980**	**33361**	**33362**	**33363**	**33364**	**33365**	**33366**
3	**Meeting Date: April 2012 Tab: 12 Specialty: ACC/STS/SCAI**	**CMS Code**	**Staff Type**	Removal of ventricular assist device, impantable intracorporeal, single ventricle (CMS Code is L015A staff type is RN)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	open femoral artery approach	open axillary artery approach	open iliac artery approach	transaortic approach (eg, median sternotomy, mediastinotomy)	transapical approach (eg, left thoracotomy)
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
12	Complete pre-service diagnostic & referral forms	L037D	RN/LP/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L037D	RN/LP/MTA	**20**	**10**	**10**	**10**	**10**	**10**	**10**
14	Schedule space and equipment in facility	L037D	RN/LP/MTA	**8**	**5**	**5**	**5**	**5**	**5**	**5**
15	Provide pre-service education/obtain consent	L037D	RN/LP/MTA	**20**	**7**	**7**	**7**	**7**	**7**	**7**
16	Follow-up phone calls & prescriptions	L037D	RN/LP/MTA	**7**	**3**	**3**	**3**	**3**	**3**	**3**
17	Other Clinical Activity - *specify:*									
18	**End: When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
43	**POST-SERVICE Period**									
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**							
62	**EQUIPMENT**	**CODE**								
63										
64										
65										
66										
67										

	A	B	C	D	E	F	G	H	I	J
1				Reference Code						
2				**33980**	**33361**	**33362**	**33363**	**33364**	**33365**	**33366**
3	**Meeting Date: April 2012 Tab: 12 Specialty: ACC/STS/SCAI**	**CMS Code**	**Staff Type**	Removal of ventricular assist device, impantable intracorporeal, single ventricle (CMS Code is L015A staff type is RN)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	open femoral artery approach	open axillary artery approach	open iliac artery approach	transaortic approach (eg, median sternotomy, mediastinotomy)	transapical approach (eg, left thoracotomy)
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
12	Complete pre-service diagnostic & referral forms	L037D	RN/LP/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L037D	RN/LP/MTA	**20**	**40**	**40**	**40**	**40**	**40**	**40**
14	Schedule space and equipment in facility	L037D	RN/LP/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	L037D	RN/LP/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	L037D	RN/LP/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**
17	Other Clinical Activity - *specify:*									
18	**End: When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
43	**POST-SERVICE Period**									
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**							
62	**EQUIPMENT**	**CODE**								
63										
64										
65										
66										
67										

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2012

Stereotactic Body Radiation

In October 2011, the CPT Editorial Panel created 32701 *Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment* to describe the work provided by the surgeon when they are involved in the planning of thoracic stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SRS/SBRT) for the treatment of lung lesions. Since 2010, the non-specific CPT code 32999 *Unlisted procedure, lungs and pleura* was used to report this service and the Panel agreed that a more specific code was necessary.

The RUC discussed the survey results from 36 thoracic surgeons and recommend the following physician time components: 25 minutes pre-service time, 60 minutes intra-service time and 15 minutes post-service time. The RUC then reviewed the survey respondents' estimated work RVUs and determined that the values were overestimated at the 25th percentile, 5.83 work RVUs. To determine an appropriate work value for this service, the RUC discussed the physician work involved in this service. The surgeons' work for this service is primarily performed in the initial planning phase for the patient's radiation treatment, which is only performed one time per treatment cycle. Once the CT simulations are obtained, the physician works collaboratively with the radiation oncologist to determine the appropriate plan, including contours, dose and fractionation. The overlap of physician work with the radiation oncologist is minimal because this service is set up so that the two physicians work interchangeably throughout the planning stage in order for the treatment to be effectively administered. In addition to this work, the surgeon is also present on the first day of delivery to ensure the patient is comfortable and able to receive the treatment.

With this understanding of the physician work, the RUC compared the surveyed code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50) and determined that a critical care procedure at 71 minutes, has more intensive, patient-focused physician work than 32701 (60 minutes intra-service) and should be valued slightly higher than the surveyed code. Additionally, the Committee reviewed CPT code 61781 *Stereotactic computer-assisted (navigational) procedure; cranial, intradural* (work RVU= 3.75) and agreed that while the physician work is more intense for 61781, 32701 has double the intra-service time, 60 minutes compared to 30 minutes, and should valued higher. Given these work value ranges, the RUC, using magnitude estimation, determined that a work RVU of 4.18 appropriately aligns 32701, relative to other services. To validate this work value across the RBRVS, the RUC compared the surveyed code to CPT code 43232 *Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)* (work RVU= 4.47) and determined that while the two services have identical intra-service time, 60 minutes, 43232 is a slightly more intense service than 32701 and should be valued higher. Finally, the RUC agreed that the work of the thoracic surgeon in this code should be compared to similar physician work performed by a radiation oncologist. Therefore, CPT code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU= 7.99) was reviewed. The

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

RUC noted that while the reference codes has more intra-service time than the surveyed code, 131 minutes compared to 60 minutes, the recommended value of 4.18 accurately accounts for the difference in time and relative value of the physician work performed in these two procedures. **The RUC recommends a work RVU of 4.18 for CPT code 32701.**

New Technology:
The specialty society requests and the RUC agrees that these three codes should be added to the new technology list.

Practice Expense:
This service is primarily performed in the facility setting and no direct practice inputs are recommended.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 32701	H1	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment (Do not report 32701 in conjunction with 77261-77799) (For placement of fiducial markers, see 31626, 32553)	000	4.18
77435		Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions (Do not report 77435 in conjunction with 77427-77432) (The same physician should not report both stereotactic radiosurgery services [32701, 63620, 63621] and radiation treatment management [77435] ~~for extracranial lesions~~)	XXX	11.87 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32701 Tracking Number H1 Original Specialty Recommended RVU: **5.83**
Presented Recommended RVU: **5.83**
Global Period: 000 RUC Recommended RVU: **4.18**

CPT Descriptor: Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old female with a biopsy proven 2.5 cm stage 1A non-small cell lung cancer (T1N0M0) located in the periphery of the right lower lobe is felt to be a poor surgical candidate because of advanced chronic obstructive pulmonary disease and is scheduled for stereotactic body radiotherapy (SRS/SBRT).

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

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

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

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

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

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 44%

Description of Pre-Service Work: Review previous medical records, evaluation of the imaging studies, appropriate lab and screening studies and obtain informed consent from the patient and family.

Description of Intra-Service Work: Stereotactic computerized imaging studies (CT, MRI, and/or PET; radiology reported separately) are obtained. A CT simulation +/- respiratory gating is performed separately in radiation oncology. The physician works with the radiation oncologist to verify that the target is optimally imaged. The treatment planning computer is utilized to process all of the stereotactic and simulation images in a planning program with image fusion. The physician collaborates with the radiation oncologist to outlin the target volume throughout the fused data sets and/or Maximum Intensity Projection data set. This process includes the integration of all imaging and functional tests previously acquired and analyzed by the physician. The physician jointly prepares the dosimetry plan with the radiation oncologist and the radiation physicist. Multiple dosimetry plans may be necessary to achieve optimal dose coverage of the target lesion while minimizing the dose to the surrounding normal structures. The plan that achieves the greatest radiation dose to the target with the least radiation risk to critical surrounding tissues is ultimately selected. The patient is then brought to the linear accelerator and positioned on the treatment table. The physician is available to make changes in the treatment plan if optimal positioning cannot be achieved. Correct positioning of the patient is radiographically verified and treatment is then delivered.

Description of Post-Service Work: The patient is stabilized and monitored. The operative note is dictated and the physician communicates with the family, nurses, and referring physician (including written and telephone reports and orders). Discharge records are prepared, medications ordered, and questions from the family and other providers are answered.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Keith Naunheim, MD; James Levett, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32701				
Sample Size:	250	**Resp N:**	36	**Response:** 14.4 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	20.00	75.00
Survey RVW:	3.00	5.83	**10.00**	21.00	33.59
Pre-Service Evaluation Time:			**70.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	30.00	**60.00**	90.00	270.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	32701	**Recommended Physician Work RVU: 4.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52342	000	5.85	**RUC Time**	291

CPT Descriptor 1 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19298	000	6.00	**RUC Time**	154

CPT Descriptor 2 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance

Other Reference CPT Code	Global	Work RVU	Time Source
31600	000	7.17	**RUC Time**

CPT Descriptor Tracheostomy, planned (separate procedure);

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32701**	**Key Reference CPT Code:** 11005	**Source of Time** **RUC Time**
Median Pre-Service Time	25.00	60.00	
Median Intra-Service Time	60.00	120.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	55.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**100.00**	**265.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	5.00	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.73	3.45
Urgency of medical decision making	3.09	4.27
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.09	3.82
Physical effort required	3.55	3.45
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.91	3.36
Outcome depends on the skill and judgment of physician	4.18	3.64
Estimated risk of malpractice suit with poor outcome	3.64	3.36

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.45	3.09
Intra-Service intensity/complexity	4.00	3.55
Post-Service intensity/complexity	3.09	2.91

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32999 or not reported

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

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2500 SRS procedures were performed on thoracic tumors in CY 2007. It is estimated that 80-90% were performed on Medicare patients.
There are currently over 60 thoracic surgeons performing SRS/SBRT services in centers across the United States.

Specialty cardiothoracic surgery Frequency 500 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 37 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of services reported under 32999 for this service.

Specialty cardiothoracic surgery Frequency 37 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33468

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
12	**ISSUE:**																																							
13	**TAB:**																																							
14						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**FAC-obs**				**Office**					**Prolonged**			
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**26**	**25**	**24**	**17**	**15**	**14**	**13**	**12**	**11**	**54**	**55**	**56**	**57**
16	**REF**	**11005**	**Debridement c**	**10**	**0.087**			**14.24**			**265**	**30**	**15**	**15**			**120**			**30**			**1**																
17	**CURRENT**				**#DIV/0!**						**0**																												
18	**SVY**	**32701**	**Thoracic target(s) de**		**0.130**	**3.00**	**5.83**	**10.00**	**21.00**	**33.59**	**165**	**70**	**10**	**10**	**2**	**30**	**60**	**90**	**270**	**15**																			
19	**REC**	**32701**	**Thoracic target(s) de**		**0.056**			**4.18**			**100**	**18**	**1**	**6**			**60**			**15**																			
20																																							
21																																							
22																																							
23																																							
24																																							
25																																							

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

CPT Long Descriptor:

Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment

Global Period: 000 Meeting Date: January, 2012

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

There are no direct practice expenses associated with this procedure.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

NA
Intra-Service Clinical Labor Activities:

NA

Post-Service Clinical Labor Activities:

NA

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Insertion of Percutaneous Ventricular Assist Device

In February 2012, the CPT Editorial Panel deleted two Category III codes (0048T and 0050T) and created four Category I codes to describe the insertion of a percutaneous ventricular assist device.

33990 ***Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only***
The RUC reviewed the survey results from 33 cardiologists and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 45 minutes, intra-service time= 60 minutes and post-service time= 40 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure), with additional time for evaluation of the patient, was appropriate for this service because while an Evaluation and Management service is typically reported on the same day, the visit is typically performed by another physician at a separate encounter. The recommended pre and post times do not overlap with Evaluation and Management services.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 12.00). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) has identical intra-service time, 60 minutes, compared to 33990 and similar physician work. Therefore, a direct crosswalk to CPT code 37220 is justified. Finally, the RUC discussed the high intensity of this service. Candidates for this procedure are urgent, high risk patients that are not eligible for surgery. These assist devices are placed to maintain the patient until an angioplasty can be performed. Therefore, the Committee concurred that this service is appropriately valued and is an intense procedure. **The RUC recommends a work RVU of 8.15 for CPT code 33990, a direct crosswalk to CPT code 37220.**

33991 ***Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture***
The RUC reviewed the survey results and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 60 minutes, intra-service time= 90 minutes and post-service time= 45 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure), with additional time for evaluation of the patient, was appropriate for this service because while an Evaluation and Management service is typically reported on the same day, the visit is typically performed by another physicians at a separate encounter. The recommended pre and post times do not overlap with Evaluation and Management services.

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The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 16.63). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT codes 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture* (work RVU= 3.73) combined have similar intra-service time, 100 minutes compared to 90, and comparable physician work to 33991. To ensure the resulting work RVU of 11.88 is relative to similar services in the RBRVS, the committee reviewed CPT code 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00, intra-service time 90 minutes) and agreed that these two services have analogous physician work and should be valued similarly. Finally, the RUC discussed the high intensity of this service. Candidates for this procedure are urgent, high risk patients that are not eligible for surgery. These assist devices are placed to tide the patient over so an angioplasty can be performed. Therefore, the Committee concurred that this service is appropriately valued and is relative to 33990, with similar intensity. **The RUC recommends a work RVU of 11.88 for CPT code 33991.**

33992 ***Removal of percutaneous ventricular assist device at separate and distinct session from insertion***

The RUC reviewed the survey results and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 30 minutes, intra-service time= 45 minutes and post-service time= 30 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure) was appropriate to evaluate and wean the patient from the assist device. The RUC also discussed the appropriate billing for this code. The typical patient, roughly 85%, receiving a percutaneous ventricular assist device will have the device removed in the catheterization laboratory during the same session as insertion. The physician work of removal in that scenario is included in the insertion codes. However, a minority of patients will require that the device be removed in the intensive care unit where 33992 would be appropriately reportable with a 59 modifier, per CPT instructions.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 6.44). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT code 31634 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed* (work RVU= 4.00) has identical intra-service time, 45 minutes, and should have the same value as the surveyed code. **The RUC recommends a work RVU of 4.00 for CPT code 33992, a direct crosswalk to CPT code 31634.**

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33993 ***Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion***
The RUC reviewed the survey results and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 30 minutes, intra-service time= 30 minutes and post-service time= 30 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure) was appropriate to evaluate a patient with a device that has position malfunction. As is the case with the removal code, 33992, 33993 can only be reported when repositioning of a device is performed during a separate encounter, which is not typical. Repositioning during insertion is not separately reportable.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 6.00). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) has identical intra-service time as 33993, 30 minutes, and analogous physician work. Therefore, the Committee agreed that the two services should be valued the same. Finally, the RUC noted that 33993 is appropriately valued compared to 33992 because although repositioning takes less time compared to the removal code, 33993 is much more intense, as shown in the intensity/complexity measures, and should be valued slightly higher. **The RUC recommends a work RVU of 4.17 for CPT code 33993, a direct crosswalk to CPT code 32550.**

Practice Expense: There are no direct practice expense inputs for these services as they are only done in the Facility setting.

New Technology: These services will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
The insertion of a ventricular assist device (VAD) can be performed via percutaneous (~~0048T~~, 33990, 33991) or transthoracic (33975, 33976, 33979) approach. The location of the ventricular assist device may be intracoporeal or extracorporeal. For surgical insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO), see 36822). Open arterial exposure when necessary to facilitate percutaneous ventricular assist device insertion (33990, 33991), ~~is~~ may be reported separately (34812). Extensive repair or replacement of an artery may be additionally reported [eg, 35226 or 35286]) Removal of a ventricular assist device (33977, 33978, 33980, ~~0050T~~, 33992) includes removal of the entire device, including the cannulas. Removal of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. For removal of a percutaneous ventricular assist device at a separate and distinct session, but on the same day as insertion, report 33992 appended with modifier 59 indicating a distinct procedural service.				
Repositioning of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. Repositioning of percutaneous ventricular assist device not necessitating imaging guidance is not a reportable service. For repositioning of a percutaneous ventricular assist device necessitating imaging guidance at a separate and distinct session, but on the same day as insertion, report 33993 with modifier 59 indicating a distinct procedural service. Replacement of the entire implantable ventricular assist device system, ie, pump(s) and cannulas, is reported using the insertion codes (ie, 33975, 33976, 33979). Removal (ie, 33977, 33978, 33980) of the ventricular assist device system being replaced is not separately reported. Replacement of a percutaneous ventricular assist device is reported using implantation codes (ie, 33990, 33991). Removal (ie 33992) is not reported separately. ~~(For implantation or removal of ventricular assist device, extracorporeal, percutaneous transseptal access, see 0048T, 0050T. For replacement of a ventricular assist device, extracorporeal, percutaneous transseptal access, use 33999)~~				
Transthoracic Cardiac Assist **Percutaneous Ventricular Assist**				

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⦿●33990	HH1	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only	XXX	8.15
⦿●33991	HH2	both arterial and venous access, with transseptal puncture	XXX	11.88
⦿●33992	HH3	Removal of percutaneous ventricular assist device at separate and distinct session from insertion	XXX	4.00
⦿●33993	HH4	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	XXX	4.17
D0048T		~~Implantation of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation~~ ~~(For prolonged extracorporeal percutaneous transseptal ventricular assist device, use 33999)~~ (0048T has been deleted. To report, use 33991)	XXX	N/A
D0050T		~~Removal of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation~~ ~~(For replacement of a ventricular assist device, extracorporeal, percutaneous transseptal access, use 33999)~~ (0050T has been deleted. To report, see 33990-33993	XXX	N/A
Surgery **Cardiovascular** **Heart and Pericardium** **~~Wounds of the~~ Heart (Including Valves) and Great Vessels**				

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Cardiopulmonary bypass may be required for patients receiving major cardiac procedures requiring insertion of cannulae into the venous and arterial circulation with placement on a cardiopulmonary bypass (ie, heart-lung) machine. Many codes are dyads so as to report procedures with cardiopulmonary bypass as contrasted to without cardiopulmonary bypass. Cardiopulmonary bypass is distinct from support of cardiac output using devices (eg, ventricular assist or intra-aortic balloon). For cardiac assist services see 33960-33983 33990-33993.

Venous Grafting Only for Coronary Artery Bypass

The following codes…

Procurement of the saphenous vein graft is included in the description of the work for 33510-33516 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs graft procurement, add modifier 80 to 33510-33516. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Combined Arterial-Venous Grafting for Coronary Bypass

The following codes…

To report combined…

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 35517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Arterial Grafting for Coronary Artery Bypass

The following code…

To report combined…

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33990 Tracking Number HH1 Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **12.00**
Global Period: XXX RUC Recommended RVU: **8.15**

CPT Descriptor: Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year-old obese male with oxygen dependent obstructive pulmonary disease, diabetes mellitus, hypertension, and dyslipidemia presents with signs of acute systolic heart failure and unstable angina. Cardiac catheterization demonstrates a left ventricular ejection fraction of 25%, down from 60% one year ago. Coronary angiography shows a 30 mm long, heavily calcified 90% stenosis in the left anterior descending artery (LAD), a 30 mm long, heavily calcified 80% stenosis in the left circumflex artery (LCX), and a 50% focal right coronary stenosis. Cardiac surgery consult deems him too high risk for surgical revascularization due to severe pulmonary disease and comorbidities. Rotational atherectomy of the calcified LAD and LCX lesions is planned with placement of arterial pVAD due to the severely impaired left ventricular function and large myocardial territories at risk.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

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

Description of Pre-Service Work: The patient's history, ECG, echocardiogram, laboratory and diagnostic tests are reviewed, including relevant coronary angiograms, CT angiograms, and ilio-femoral contrast angiograms. This includes review of the CT and/or angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. The potential access sites are prepped. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is

loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

A peripheral IV access site is obtained. If general anesthesia is induced, the patient is intubated and connected to a mechanical ventilator. If conscious sedation is used, oxygen saturation monitoring is secured. A radial artery catheter may be inserted for hemodynamic monitoring. The heart rate and rhythm are monitored throughout the procedure. Transesophageal echocardiography (TEE) or transthoracic echocardiography (TTE) may be used by an echocardiographer to confirm ejection fraction and to rule out ventricular thrombus. (If performed, TTE/TEE is separately reported). The patient is prepped and draped.

Femoral arterial access for the reference pigtail catheter is obtained by needle puncture (modified Seldinger technique). After arterial access is obtained, serial dilation of the femoral artery is performed up to 11Fr. A 13 French peel-away sheath or a 14 F indwelling sheath is then positioned in the femoral artery over a standard guide wire. (Note: the device is available in both 13F and 21F versions). A catheter is then advanced over a wire from the femoral artery up to the ascending aorta and then used to cross the aortic valve into the left ventricle. The standard guide wire is exchanged out through the catheter for the transcatheter pVAD guidewire, which is then positioned in the ventricle toward the apex. The catheter is then withdrawn over the wire leaving the wire alone in the ventricle. This typically generates significant ventricular ectopy and repositioning of the wire. Using fluoroscopic guidance, the pVAD device is backloaded on to the guidewire and then advanced over the wire, into the aortoiliac system, around the aortic arch, through the aortic valve and into the ventricle. The wire is removed. Under fluoroscopic guidance the pVAD catheter is positioned so that the inflow of the cannula is properly positioned below the aortic valve. The pVAD transcatheter/transvalvular catheter is then activated to counteract the passive flow through the catheter from the aorta. In this manner, the pump is in a transvalvular position with uptake placed in the ventricle and arterial delivery into the aorta. The other end of the pVAD catheter exits through the arterial access site, and is fixed externally to prevent untoward inward migration (too much catheter inside the heart). The external end of the device is connected to the control console and the pump is adjusted as needed to optimize its output.

During the interventional procedure, the transcatheter/transvalvular assist device is adjusted as necessary to achieve an optimal performance level in order to maintain systolic pressure during long inflations of the coronaries and to provide unloading of the ventricle during the entire procedure.

If device removal is appropriate at conclusion of case, weaning of the pump is gradually performed. The patient's temperature, hematocrit, level of oxygenation and electrolytes are normalized as necessary. Once the transcatheter device is set at a low, or a neutral setting (no forward flow), the pump is withdrawn to the iliac artery and turned off. Once the ACT is reduced to <150 seconds, the pump is withdrawn through the sheath and removed. Arterial hemostasis is achieved with prolonged manual pressure or via an arterial closure system. The patient has vital signs recorded every hour until release to the step down unit with checks of the groin by nursing every hour for the next four hours then every two hours as directed.

Description of Post-Service Work: The physician confirms the hemodynamics upon arrival to the recovery area. Post-op orders are written. The family and referring physician are apprised of the procedure outcome. The results of the procedure are reviewed with the patient after sedation wears off. Intra-procedural images are reviewed, interpreted and archived. The patient's fluoroscopic exposure time and contrast administration volume are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary and signed. A formal report is sent to the PCP and referring providers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD		
Specialty(s):	ACC, SCAI		
CPT Code:	33990		
Sample Size:	265	**Resp N:** 33	**Response:** 12.4 %
Description of Sample:	Panel sample drawn from institutions identified by the manufacturer of the device and institutions identified in published literature on the technology and an additional 200 random interventional cardiologists		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**8.00**	15.00	50.00
Survey RVW:	6.00	12.00	**15.00**	20.00	40.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	60.00	**60.00**	90.00	180.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	33990	**Recommended Physician Work RVU: 8.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**39.00**	**0.00**	**39.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**0.00**	**5.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99475	XXX	11.25	**RUC Time**	64

CPT Descriptor 1 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99471	XXX	15.98	**RUC Time**	35

CPT Descriptor 2 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 21.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 33990**	**Key Reference CPT Code:** 93580	**Source of Time** **RUC Time**
Median Pre-Service Time	45.00	30.00	
Median Intra-Service Time	60.00	120.00	
Median Immediate Post-service Time	40.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**145.00**	**210.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.71	4.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	4.43
Urgency of medical decision making	4.86	3.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.71	4.86
Physical effort required	4.14	3.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.71	4.57
Outcome depends on the skill and judgment of physician	4.71	4.71
Estimated risk of malpractice suit with poor outcome	4.43	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.71	4.86
Intra-Service intensity/complexity	4.86	4.86
Post-Service intensity/complexity	4.57	4.29

Additional Rationale and Comments

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

Percutaneous ventricular assist devices (PVADs) are used for certain patients as aides to recovery following percutaneous coronary interventions or in patients with cardiogenic shock as a bridge to other therapies. This technology is distinct from

the more commonly known ventricular assist devices that are implanted by surgeons. Devices are placed and removed during a single hospital stay.

This service has developed in recent years and was granted Category III codes in 2006. At the February meeting of the CPT Editorial Panel, four new Category I codes were created – 33990 and 33991 describe implantation of the device, 33992 describes the removal of the device if not placed at the same time, and 33993 covers a repositioning of the device under fluoroscopy.

The ACC and SCAI completed a survey of the PVAD codes. Because of the relatively low utilization of the services, surveyees were drawn from a list of centers that had been identifying as providing the service buttressed by a random sample of interventional cardiologists from the ACC member database. Research Subcommittee approved this request.

An expert panel of ACC and SCAI physicians reviewed the data from the survey. Although the response rate was relatively low, the panel believed the survey was valid. The survey median RVU was 15 – while the expert panel agreed that the service was intense, they did not believe that it justified 15 RVUs. They believed that the 25th percentile RVU of 12 RVUs was more appropriate. The key reference service of 93580 has a much higher of RVU of 17.97 but a much longer total time – 210 total minutes in comparison to 145 minutes of total time for the surveyed code. The comparison of intensity and complexity showed that survey respondees considered both services to be very complex but the urgency of medical decision making to be quite a bit higher for the surveyed 33990 code.

The panel also reviewed the times reported by the surveyees and thought they represented the time required to complete the service. Since the service is an XXX code, there is no pre-service package associated with the service. The panel used the times associated with pre-service package 2B (difficult patient, straightforward procedure) to determine the appropriate level of time to associate with positioning and scrub, dress, and wait. The remainder of the pre-service time from the survey was assigned to the evaluation time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Percutaneous ventricular assist devices may be used in conjunction with percutaneous coronary interventions including atheretomy and stent but also may be used alone. In cases in which the PCI and the PVAD are used together, the less valuable procedure would be reduced by 50% in accordance with the multiple procedure edits. It is only used in a small minority of PCI cases.

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0048T

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. based on expert opinion

Specialty cardiology Frequency 3000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. based on expert opinion

Specialty cardiology Frequency 1500 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33240

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33991 Tracking Number HH2 Original Specialty Recommended RVU: **16.63**
Presented Recommended RVU: **16.63**
Global Period: XXX RUC Recommended RVU: **11.88**

CPT Descriptor: Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year-old obese male with oxygen dependent obstructive pulmonary disease, diabetes mellitus, hypertension, and dyslipidemia presents with signs of acute systolic heart failure and unstable angina. Cardiac catheterization demonstrates a left ventricular ejection fraction of 15%, down from 60% one year ago. Coronary angiography shows a 30 mm long, heavily calcified 90% stenosis in the left anterior descending artery (LAD), a 30 mm long, heavily calcified 80% stenosis in the left circumflex artery (LCX), and a 50% focal right coronary stenosis. Cardiac surgery consult deems him too high risk for surgical revascularization due to severe pulmonary disease and comorbidities. Rotational atherectomy of the calcified LAD and LCX lesions is planned with placement of arterial-venous pVAD with transseptal puncture due to the severely impaired left ventricular function and large myocardial territories at risk.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 73%

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

Description of Pre-Service Work: The patient's history, ECG, echocardiogram, laboratory and diagnostic tests are reviewed, including relevant coronary angiograms, CT angiograms, and ilio-femoral contrast angiograms. This includes review of the CT and/or angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. The potential venous and arterial access sites are prepped. Instruments and supplies for the procedure are pulled, including trans-septal puncture needle and equipment if necessary. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The injection manifold and

hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

Description of Intra-Service Work: A peripheral IV access site is obtained. If general anesthesia is induced, the patient is intubated and connected to a mechanical ventilator. If conscious sedation is used, oxygen saturation monitoring is secured. Pulmonary and radial artery catheters may be inserted for hemodynamic monitoring. The heart rate and rhythm are monitored throughout the procedure. Transesophageal echocardiography (TEE) or transthoracic echocardiography (TTE) may be used by an echocardiographer to confirm ejection fraction and to rule out left atrial thrombus (if performed, TEE is separately reported). The patient is prepped and draped.

The femoral artery and femoral vein are accessed percutaneously or by cutdown. An appropriate catheter is inserted over a wire through the venous sheath into the venous system under fluoroscopic guidance up to the superior vena cava. The wire is removed. A rigid transeptal puncture needle is carefully advanced through the catheter stopping just short of the end of the catheter. The needle-catheter unit is flushed and attached to a second pressure manifold and then withdrawn to the level of the fossa ovalis in the interatrial septum under fluoroscopic guidance. The imaging system is rotated in both the anterior and lateral positions to confirm proper positioning with respect to the arterial catheter positioned just above the aortic valve. The needle-catheter unit is then advanced several millimeters while observing the pressure waveform. The transeptal puncture is achieved. Left atrial position is confirmed by pressure waveform analysis, oxygen saturation measurement, and contrast injection through the system. If the needle-catheter unit has not traversed the septum properly, complications are first excluded and then the device is repositioned and repeat attempt is performed until successful. The transseptal procedure typically requires more than one attempt to achieve success. The transseptal needle is removed, the catheter flushed, and a wire advanced through the catheter into the left atrium. The catheter is removed and an dilating catheter is advanced over the wire across the interatrial septum into the left atrium in order to dilate the septum. The venous access site is progressively dilated over a wire to allow placement of a large bore cannula. The large bore 21F venous pVAD cannula is flushed and then advanced over the wire into the left atrium under fluoroscopic guidance. The femoral artery is progressively dilated over the previously placed wire to allow placement of a large bore 16F pVAD arterial return catheter, which is advanced over the wire into the proximal iliac artery or distal aorta for arterial return. The pVAD cannulas are deaired and connected to the external pump. The pump is activated and proper flows are ensured. If flows are inadequate, suggesting malpositioning of the left atrial cannula, the cannula is repositioned under fluoroscopic guidance. During the interventional procedure, the pump is running at high performance level and thus maintains delivery of oxygenated blood to the body while the heart is compromised and unloads the heart during the entire procedure.

If device removal is appropriate at conclusion of case, weaning of the pump is gradually performed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are normalized as necessary and the patient is weaned. The heart pump console is turned off. The left atrial catheter is withdrawn from the atrium, into the inferior vena cava, and once the ACT is reduced to <150 seconds the device is ultimately withdrawn from the femoral vein, under direct fluoroscopic or echocardiographic guidance. Prolonged manual compression is applied to the exit site to achieve hemostasis and a deep skin suture may also be applied to the area around the cannulation site to enhance hemostasis. The arterial catheter(s) is/are usually removed and arterial hemostasis is achieved with prolonged manual compression, with an arterial closure system, or by surgical closure. The patient has vital signs recorded every hour until release to the step down unit with checks of the groin by nursing every hour for the next four hours then every two hours as directed.

Description of Post-Service Work: The physician confirms the hemodynamics upon arrival to the recovery area. Post-op orders are written. The family and referring physician are apprised of the procedure outcome. The results of the procedure are reviewed with the patient after sedation wears off. Intra-procedural images are reviewed, interpreted and archived. The patient's fluoroscopic exposure time and contrast administration volume are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary and signed. A formal report is sent to the PCP and referring providers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	33991				
Sample Size:	265	**Resp N:**	26	**Response:** 9.8 %	
Description of Sample:	Panel sample drawn from institutions identified by the manufacturer of the device and institutions identified in published literature on the technology and an additional 200 random interventional cardiologists				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	6.00	50.00
Survey RVW:	6.00	16.63	**18.38**	24.75	50.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	40.00	60.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	33991	**Recommended Physician Work RVU: 11.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**54.00**	**0.00**	**54.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**0.00**	**5.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99471	XXX	15.98	**RUC Time**	35

CPT Descriptor 1 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99468	XXX	18.46	**RUC Time**	1

CPT Descriptor 2 Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 30.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 33991**	**Key Reference CPT Code:** 93581	**Source of Time** **RUC Time**
Median Pre-Service Time	60.00	30.00	
Median Intra-Service Time	90.00	180.00	
Median Immediate Post-service Time	45.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**195.00**	**270.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.71	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.86	4.43
Urgency of medical decision making	5.00	3.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.86	4.57
Physical effort required	4.71	4.57
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.86	4.00
Outcome depends on the skill and judgment of physician	5.00	4.29
Estimated risk of malpractice suit with poor outcome	4.43	3.22

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.71	4.00
Intra-Service intensity/complexity	4.86	4.43
Post-Service intensity/complexity	4.71	4.00

Additional Rationale and Comments

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

Percutaneous ventricular assist devices (PVADs) are used for certain patients as aides to recovery following percutaneous coronary interventions or in patients with cardiogenic shock as a bridge to other therapies. This technology is distinct from

the more commonly known ventricular assist devices that are implanted by surgeons. Devices are placed and removed during a single hospital stay.

This service has developed in recent years and was granted Category III codes in 2006. At the February meeting of the CPT Editorial Panel, four new Category I codes were created – 33990 and 339901 describe implantation of the device, 33992 describes the removal of the device if not placed at the same time, and 33993 covers a repositioning of the device under fluoroscopy.

The ACC and SCAI completed a survey of the PVAD codes. Because of the relatively low utilization of the services, surveyees were drawn from a list of centers that had been identifying as providing the service buttressed by a random sample of interventional cardiologists from the ACC member database. The response rate for this particular survey was lower than the others in the family reflecting the relatively rarity of the procedure. However, the panel thought that the data was valid and decided to proceed with recommendations.

The panel reviewed the 33991 both in comparison to other codes in the cardiovascular family as well as the 33990 code. They believed that the service, while intense, did not justify the median RVU of 18.38. Instead, the panel recommended the 25th percentile RVU of 16.63. This value demonstrates a much longer operating time than the 33990 code but a somewhat lower intensity. The key reference code of 93581 has a much higher work value but also reflects an intraservice time that is twice as long as the surveyed 33991 code. However, the survey respondents considered the surveyed code to be extraordinarily intense, in some cases universally reporting at the highest level of intensity.

The panel also reviewed the times reported by the surveyees and thought they represented the time required to complete the service. Since the service is an XXX code, there is no pre-service package associated with the service. The panel used the times associated with pre-service package 2B (difficult patient, straightforward procedure) to determine the appropriate level of time to associate with positioning and scrub, dress, and wait. The remainder of the pre-service time from the survey was assigned to the evaluation time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Percutaneous ventricular assist devices may be used in conjunction with percutaneous coronary interventions including atheretomy and stent but also may be used alone. In cases in which the PCI and the PVAD are used together, the less valuable procedure would be reduced by 50% in accordance with the multiple procedure edits. It is only used in a small minority of PCI cases.

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) using 0048T, a Category III code deleted as part of this application

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

Specialty Cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert opinion

Specialty cardiology Frequency 500 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. expert opinion

Specialty cardiology Frequency 250 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33240

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33992 Tracking Number HH3 Original Specialty Recommended RVU: **6.44**
Presented Recommended RVU: **6.44**
Global Period: XXX RUC Recommended RVU: **4.00**

CPT Descriptor: Removal of percutaneous ventricular assist device at separate and distinct session from insertion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year old man presents with a large anterior STEMI and progresses rapidly to cardiogenic shock. An arterial-venous pVAD is implanted emergently. Despite successful stent placement to the occluded proximal left anterior descending artery, he manifests persistent hypotension, pulmonary edema, and EF 25%. The pVAD is maintained in place for prolonged hemodynamic support post procedure. Two days later, he has clinically improved with ejection fraction up to 35%. He remains stable during weaning of the pVAD and the device is now removed successfully.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

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

Description of Pre-Service Work: The patient is weaned from the pVAD as the native heart improves function. In most cases, patients are no longer in the cath lab procedure room but in a critical care setting when this device removal is contemplated. Typically, patients will be brought back to the catheterization laboratory or surgical suite for device removal. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are normalized as necessary and the patient is weaned.

Description of Intra-Service Work: For arterial approach only devices, the device flow is reduced to minimal flow (or neutral setting), and withdrawn from the ventricle into the aorta, under fluoroscopic or echocardiographic guidance. Once it approaches the iliac artery it is turned off and with the ACT <150 seconds the device is removed. The arterial catheter(s) is/are removed and arterial hemostasis is achieved with prolonged manual compression, with an arterial closure system, or by surgical closure. The patient has vital signs recorded every hour until release to the step down unit with checks of the groin by nursing every hour for the next four hours then every two hours as directed.

For arterial-venous approach devices, the heart pump console is turned off. The left atrial catheter is withdrawn from the left atrium, across the right atrium, into the inferior vena cava and, once the ACT is reduced to <150 seconds, ultimately withdrawn from the femoral vein under direct fluoroscopic or echocardiographic guidance. Prolonged manual compression is applied to the exit site to achieve hemostasis and a deep skin suture may also be applied to the area around the cannulation site to enhance hemostasis. The arterial catheter(s) is/are removed and manual pressure applied or the artery is closed surgically with prolonged manual compression, with an arterial closure system, or by surgical closure. The

patient has vital signs recorded every hour until release to the step down unit with checks of the groin by nursing every hour for the next four hours then every two hours as directed.

Description of Post-Service Work: During the immediate post-procedure period, the physician evaluates and manages the patient's hemodynamics and bleeding in order to ascertain stability post-device removal, as this period is vital in terms of confirming that removal was clinically appropriate. In addition, failure to achieve adequate hemostasis must be addressed urgently. If there is a clinically apparent decrement in cardiac function, the physician must decide whether replacement of the support device or alternate therapies are necessary, including inotrope/medical therapies as appropriate. Because the typical patient is not stable, multiple adjustments of inotropic/vasoactive agents and volume status are determined minute to minute. In addition, the physician talks to family, nursing and other staff, talks to and coordinates care with other physicians, writes orders, writes a procedure note, and discusses outcome with patient and family during this time.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	33992				
Sample Size:	265	**Resp N:**	32	**Response:** 12.0 %	
Description of Sample:	Panel sample drawn from institutions identified by the manufacturer of the device and institutions identified in published literature on the technology and an additional 200 random interventional cardiologists				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**6.00**	10.00	50.00
Survey RVW:	5.00	6.44	**9.38**	10.00	35.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	33992	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**24.00**	**0.00**	**24.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**0.00**	**5.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33973	000	9.75	**RUC Time**

CPT Descriptor Insertion of intra-aortic balloon assist device through the ascending aorta

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95951	XXX	5.99	**RUC Time**	63,459

CPT Descriptor 1 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99472	XXX	7.99	**RUC Time**	393

CPT Descriptor 2 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 28.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 33992**	**Key Reference CPT Code:** 33973	**Source of Time** **RUC Time**
Median Pre-Service Time	30.00	60.00	
Median Intra-Service Time	45.00	75.00	
Median Immediate Post-service Time	30.00	210.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**105.00**	**345.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.50
Urgency of medical decision making	3.38	3.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.63	3.50
Physical effort required	3.50	3.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.88	3.50
Outcome depends on the skill and judgment of physician	3.88	3.50
Estimated risk of malpractice suit with poor outcome	3.63	2.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.43	3.00
Intra-Service intensity/complexity	3.57	3.43
Post-Service intensity/complexity	3.14	2.86

Additional Rationale and Comments

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

Percutaneous ventricular assist devices (PVADs) are used for certain patients as aides to recovery following percutaneous coronary interventions or in patients with cardiogenic shock as a bridge to other therapies. This technology is distinct from

the more commonly known ventricular assist devices that are implanted by surgeons. Devices are placed and removed during a single hospital stay.

This service has developed in recent years and was granted Category III codes in 2006. At the February meeting of the CPT Editorial Panel, four new Category I codes were created – 33990 and 33991 describe implantation of the device, 33992 describes the removal of the device if not placed at the same time, and 33993 covers a repositioning of the device under fluoroscopy.

The ACC and SCAI completed a survey of the PVAD codes. Because of the relatively low utilization of the services, surveyees were drawn from a list of centers that had been identifying as providing the service buttressed by a random sample of interventional cardiologists from the ACC member database. An ACC/SCAI expert panel reviewed the survey data and thought the data was a valid starting point for making a recommendation.

The surveyed 33992 code covers the removal of the device at a separate session from the initial placement. In some cases, the device is removed on the same day as the initial implantation – in those cases, this code would not be reported. However, in other cases, the device remains in the patient for more than a single day or recovery. Removal would then be reported using this code.

The work values from the survey were compared to the reference service of 33973 and other services within the family. The surveyees indicated that the service was less intense than either than the initial placement or the repositioning of the device, reflecting less technical skill required and clinical risk to remove the device than to place it properly. The panel did not feel that the median work value of 9.38 was supported but did feel that the 25th percentile work value of 6.44 was appropriate. While the key comparison code has a much longer time, the panel noted that it was value in the early days of the RUC using a different instrument, and times from that era have tended to be longer. The panel also noted that the long total time is more reflective of the lengthy post time associated with the reference code than the differences in the intraservice time in the procedures.

The panel also reviewed the times reported by the surveyees and thought they represented the time required to complete the service. Since the service is an XXX code, there is no pre-service package associated with the service. The panel used the times associated with pre-service package 2B (difficult patient, straightforward procedure) to determine the appropriate level of time to associate with positioning and scrub, dress, and wait. The remainder of the pre-service time from the survey was assigned to the evaluation time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Previously reported with 0050T, which has been deleted as part of this application

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

Specialty cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. based on expert opinion

Specialty cardiology Frequency 3000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. based on expert opinion

Specialty cardiology Frequency 1500 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33240

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33993 Tracking Number HH4 Original Specialty Recommended RVU: **6.00**
Presented Recommended RVU: **6.00**
Global Period: XXX RUC Recommended RVU: **4.17**

CPT Descriptor: Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old man presents with a large anterior STEMI and progresses rapidly to cardiogenic shock. An arterial pVAD is implanted emergently. Despite successful stent placement to the occluded proximal left anterior descending artery, he manifests persistent hypotension, pulmonary edema, and EF 25%. The pVAD is maintained in place for prolonged hemodynamic support post procedure. Upon transfer to the coronary care unit, the patient's oxygen saturation and blood pressure drop, and an alarm sounds on the device console. Vasopressors are started to augment blood pressure. Echocardiogram confirms the pVAD has come back from the desired left ventricular position to a position now completely in the ascending aorta, indicating the need to reposition the device. The patient is brought back to the catheterization laboratory, where the device is repositioned into the left ventricular under fluoroscopic guidance.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 69%

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

Description of Pre-Service Work: When device position malfunction occurs, the patient is returned to the catheterization lab or hybrid lab for urgent fluoroscopic and/or echocardiographic visualization. Such patients are typically continuing on support due to ongoing hemodynamic instability so the patient is connected to the physiologic monitoring available there. The access site(s) is/are usually prepared as if for another sterile procedure, and the patient draped. Repositioning is performed under fluoroscopic and/or echocardiographic guidance.

Description of Intra-Service Work: For the venous only approach, the devices are visualized and repositioned as necessary with respect to the right atrium and pulmonary artery as needed. For the arterial approach devices, the pump is visualized and the device is repositioned with respect to the aortic valve as needed. For the combined arterial and venous devices, the venous and arterial cannulas are visualized and repositioned as necessary with respect to the right atrium and aortoiliac system. For the combined arterial and venous devices with transeptal access, the venous and arterial cannulas are visualized and repositioned as necessary with respect to the right and left atria and the aortoiliac system. Once back in position, the pump is restarted to maintain adequate cardiac support.

Description of Post-Service Work: During the immediate post-repositioning period, the physician evaluates and manages the patient's hemodynamics in order to ascertain stability post-device repositioning, as this period is vital in terms of

confirming that repositioning was clinically successful. This may include evaluation of post-procedure echocardiogram performed at the bedside, or analysis of cardiac output or other hemodynamic indices. Because the typical patient is not stable, multiple adjustments of inotropic/vasoactive agents and volume status are determined minute to minute, as well as more minor repositioning of the device. The physician also works with the rest of the team, including other physicians and nurses, in order to increase stability of the device position externally, so that device movement is minimized. In addition, the physician talks to family, nursing and other staff, talks to and coordinates care with other physicians, writes orders, writes a procedure note, and discusses outcome with patient and family during this time.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD					
Specialty(s):	ACC, SCAI					
CPT Code:	33993					
Sample Size:	265	**Resp N:**	36	**Response:** 13.5 %		
Description of Sample:	Panel sample drawn from institutions identified by the manufacturer of the device and institutions identified in published literature on the technology and an additional 200 random interventional cardiologists					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.75	**3.00**	6.00	50.00
Survey RVW:		3.00	6.00	**8.00**	10.00	35.00
Pre-Service Evaluation Time:				**30.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		10.00	30.00	**30.00**	60.00	180.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

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

Specialty Society Recommended Data

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

CPT Code:	33993	**Recommended Physician Work RVU: 4.17**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**24.00**	**0.00**	**24.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**0.00**	**5.00**
Intra-Service Time:		**30.00**		
Immediate Post Service-Time:	**30.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**		
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**		

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33973	000	9.75	**RUC Time**

CPT Descriptor Insertion of intra-aortic balloon assist device through the ascending aorta

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95951	XXX	5.99	**RUC Time**	63,459

CPT Descriptor 1 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99472	XXX	7.99	**RUC Time**	393

CPT Descriptor 2 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 33993**	**Key Reference CPT Code:** 33973	**Source of Time** **RUC Time**
Median Pre-Service Time	30.00	60.00	
Median Intra-Service Time	30.00	75.00	
Median Immediate Post-service Time	30.00	210.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**90.00**	**345.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.67
Urgency of medical decision making	4.33	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.58
Physical effort required	3.42	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	3.33
Outcome depends on the skill and judgment of physician	3.42	3.50
Estimated risk of malpractice suit with poor outcome	3.67	3.40

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.92	3.67
Intra-Service intensity/complexity	3.58	3.50
Post-Service intensity/complexity	3.50	3.33

Additional Rationale and Comments

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

Percutaneous ventricular assist devices (PVADs) are used for certain patients as aides to recovery following percutaneous coronary interventions or in patients with cardiogenic shock as a bridge to other therapies. This technology is distinct from

the more commonly known ventricular assist devices that are implanted by surgeons. Devices are placed and removed during a single hospital stay.

This service has developed in recent years and was granted Category III codes in 2006. At the February meeting of the CPT Editorial Panel, four new Category I codes were created – 33990 and 33991 describe implantation of the device, 33992 describes the removal of the device if not placed at the same time, and 33993 covers a repositioning of the device under fluoroscopy.

The ACC and SCAI completed a survey of the PVAD codes. Because of the relatively low utilization of the services, surveyees were drawn from a list of centers that had been identifying as providing the service buttressed by a random sample of interventional cardiologists from the ACC member database.

An expert panel of ACC and SCAI physicians reviewed the data from the survey. While the service was considered intense, the panel did not believe that the median work value of 8 would allow for an appropriate rank order with other services within the family based on earlier recommendations. The panel and the surveyees seemed to indicate that the intensity for the repositioning of the device was comparable to the initial placement of the device, reflecting the skilled work required to place the device in the correct position within the vessels. As in the 33992 removal code, the key reference service of 33973 included a great deal more time than the surveyed 33993 code. However, the panel again noted that 33973 includes a significant post procedure time and that it was valued in the early days of the RUC using a different instrument that appeared to have resulted in generally longer times. In comparing the service to the intensity of the other codes in the family, the panel thought that the service fit properly within the family.

The panel also reviewed the times reported by the surveyees and thought they represented the time required to complete the service. Since the service is an XXX code, there is no pre-service package associated with the service. The panel used the times associated with pre-service package 2B (difficult patient, straightforward procedure) to determine the appropriate level of time to associate with positioning and scrub, dress, and wait. The remainder of the pre-service time from the survey was assigned to the evaluation time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. based on expert opinion

Specialty cardiology Frequency 2500 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. based on expert opinion

Specialty cardiology Frequency 1250 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33240

SS Rec Summary

ISSUE: Insertion of Percutaneous Ventricular Assist Device

TAB: 13

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	7	0.133			17.97			210	30					120			60
CURRENT	0048T	Implantation of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation		#DIV/0!						0									
SVY	33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only	33	0.218	6.00	12.00	15.00	20.00	40.00	145	45			20	60	60	90	180	40
REC	33990			0.105			8.15			145	39	1	5			60			40

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	8	0.124			24.39			270	30					180			60
REF	93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	8	0.133			17.97			210	30					120			60
CURRENT	0048T	Implantation of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation		#DIV/0!						0									
SVY	33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture	26	0.178	6.00	16.63	18.38	24.75	50.00	195	60			40	60	90	120	180	45
REC	33991			0.107			11.88			195	54	1	5			90			45

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	33973	Insertion of intra-aortic balloon assist device through the ascending aorta	9	0.049			9.75			345	60					75			210
CURRENT	0050T	Removal of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation		#DIV/0!						0									
SVY	33992	Removal of percutaneous ventricular assist device at separate and distinct session from insertion	32	0.179	5.00	6.44	9.38	10.00	35.00	105	30			20	30	45	60	120	30
REC	33992			0.061			4.00			105	24	1	5			45			30

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	33973	Insertion of intra-aortic balloon assist device through the ascending aorta	12	0.049			9.75			345	60					75			210
CURRENT	none			#DIV/0!						0									
SVY	33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	36	0.222	3.00	6.00	8.00	10.00	35.00	90	30			10	30	30	60	180	30
REC	33993			0.097			4.17			90	24	1	5			30			30

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

April 2012

Cervicocerebal Angiography

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup. In January 2012, the RUC requested that new guidelines and 8 codes to bundle selective catheter placement with radiological supervision and interpretation, including angiography, be established. The specialty societies report that non-invasive vascular imaging has replaced diagnostic angiography as a screening test. The use of routine noninvasive vascular imaging for diagnosis means that the smaller patient population undergoing catheter cerebral angiography are inherently a more complex patient population. These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology.

36221 *Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=30 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is included in the post-service period to ensure that there is no change in deficits, because a stroke continues to be a significant risk factor in these procedures. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC compared 36221 to the key reference service 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU=5.35) and determined that the two codes have similar total time at 118 and 116, respectively. 36221 has slightly higher intensity than 36251, however the additional time for 36251 is in the intra-service period at 45 minutes, which accounts for the higher RVU. The RUC agreed with the specialty societies that in order to maintain rank order and magnitude of estimation a direct crosswalk to the two component codes being bundled, CPT codes 36200 *Introduction of catheter, aorta* (work RVU=3.02) and 75650 *Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation* (work RVU=1.49), is justified.
The RUC recommends a work RVU of 4.51 for CPT code 36221, a direct crosswalk to CPT codes 36200 and 75650.

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36222 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=40 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the median survey RVU of 6.00 is an accurate measure of the physician work involved in this service. The RUC compared 36222 to the key reference service 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU=5.35) and determined that 36222 has more total time at 128 and 116, respectively, and significantly higher level of intensity to perform. These factors account for the higher RVU. **The RUC recommends a work RVU of 6.00 for CPT code 36222.**

36223 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=45 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation.. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the physician work of 36223 is analogous to the work of 36225. Both services have identical survey median times and thus should be valued identically. Therefore, the RUC recommends a work RVU of 6.50, the survey median for 36223. The RUC compared 36223 to the key reference service CPT code 36253 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation,*

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including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (work RVU=7.55) and determined that the two codes have similar total time at 133 and 131 and similar levels of intensity to perform. The additional time for 36253 is in the intra-service period at 60 minutes (as compared to 45 minutes for 36223), which accounts for the higher RVU. **The RUC recommends a work RVU of 6.50 for CPT code 36223.**

36224 *Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=50 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the survey median, 8.00 work RVUs, was too high for this procedure. The RUC compared 36224 to the key reference service CPT code 36253 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU=7.55) and determined that the two codes have similar total time at 138 and 131 and that 36224 requires a slightly higher level of intensity to perform. The RUC agreed that these two services have similar physician work and should be valued identically. **The RUC recommends a work RVU of 7.55, a direct crosswalk to CPT code 36253, for CPT code 36224.**

36225 *Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=45 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the physician work of 36225 is analogous to the work of 36223. Both services have identical survey median times and thus should be valued identically. The RUC agreed with the specialties that the median survey RVU of 6.50 is an

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accurate measure of the physician work involved in this service. The RUC compared 36225 to the key reference service CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU=5.35) and determined that the codes have identical intra-service times at 45 minutes. 36225 has more total time at 133 and 116, respectively, and a significantly higher level of intensity to perform. These factors account for the higher RVU. **The RUC recommends a work RVU of 6.50 for CPT code 36225.**

36226 *Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=50 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the survey median, 8.00 work RVUs, was too high for this procedure. The RUC compared 36226 to the key reference service CPT code 36253 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU=7.55) and determined that the two codes have similar total time at 138 and 131 and a 36226 has a higher level of intensity to perform. The RUC agreed that these two services have similar physician work and should be valued identically. **The RUC recommends a work RVU of 7.55, a direct crosswalk to CPT code 36253, for CPT code 36226.**

36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)*
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=0 minutes, intra-service time=15 minutes and post-service time=0 minutes. The specialty societies recommended 10 minutes of post-service time for review and interpretation of the imaging sequences, however the RUC found that post-service time is not appropriate for ZZZ codes and the additional review and interpretation was accounted for in the base codes, as well as the intra-service time as described. The RUC discussed the estimated survey work values and agreed that the respondents overestimated the physician work involved in the service. The RUC agreed with the specialty societies that in order to maintain rank order and magnitude of estimation a direct crosswalk to the two component codes being bundled CPT codes 36218 *Selective catheter placement,*

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arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate) (work RVU=1.01) and 75660 *Angiography, external carotid, unilateral, selective, radiological supervision and interpretation* (work RVU=1.31), is justified. **The RUC recommends a work RVU of 2.32 for CPT code 36227, a direct crosswalk to CPT codes 36218 and 75660.**

36228 *Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)*
The RUC reviewed the survey results from 55 multi-specialty respondents and recommends to a work RVU of 4.25, the survey's 25th percentile. The RUC agreed with the specialty societies that there is 30 minutes intra-service time for this ZZZ global service. The RUC discussed whether or not post-service time was appropriate for this service and agreed that post-service time is not appropriate for ZZZ codes and the additional review and interpretation was accounted for in the base codes, as well as intra-service time as described. The RUC compared 36228 to the key reference service CPT code 61642 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)* (work RVU=8.66) and determined that 61642 has significantly more intra-service time at 60 minutes accounting for the higher RVU. The RUC also compared 36228 to CPT code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)* (work RVU=4.12) and noted that the codes are both ZZZ global service and have identical intraservice time, 30 minutes. **The RUC recommends a work RVU of 4.25 for CPT code 36228.**

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

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Diagnostic Studies of Cervicocerebral Arteries. Codes 36221-36228 describe non-selective and selective arterial catheter placement and diagnostic imaging of the aortic arch, carotid, and vertebral arteries. Codes 36221-36226 include the work of accessing the vessel, placement of catheter(s), contrast injection(s), fluoroscopy, radiological supervision and interpretation, and closure of the arteriotomy by pressure, or application of an arterial closure device. Codes 36221-36228 describe arterial contrast injections with arterial, capillary, and venous phase imaging, when performed. Code 36227 is an add-on code to report unilateral selective arterial catheter placement and diagnostic imaging of the ipsilateral external carotid circulation and includes all the work of accessing the additional vessel, placement of catheter(s), contrast injection(s), fluoroscopy, radiological supervision and interpretation. Code 36227 is reported in conjunction with 36222, 36223, or 36224. Code 36228 is an add-on code to report unilateral selective arterial catheter placement and diagnostic imaging of the initial and each additional intracranial branch of the internal carotid or vertebral arteries. Code 36228 is reported in conjunction with 36224 or 36226. This includes any additional second or third order catheter selective placement in the same primary branch of the internal carotid, vertebral, or basilar artery and includes all the work of accessing the additional vessel, placement of catheter(s), contrast injection(s), fluoroscopy, radiological supervision and interpretation. It is not reported more than twice per side regardless of the number of additional branches selectively catheterized. Codes 36221-36226 are built on progressive hierarchies with more intensive services inclusive of less intensive services. The code inclusive of all of the services provided for that vessel should be reported (ie, use the code inclusive of the most intensive services provided). Only one code in the range 36222-36224 may be reported for each ipsilateral carotid territory. Only one code in the range 36225-36226 may be reported for each ipsilateral vertebral territory. Code 36221 is reported for non-selective arterial catheter placement in the thoracic aorta and diagnostic imaging of the aortic arch and great vessel origins. Codes 36222-X8 are reported for unilateral artery catheterization. Do not report code 36221 in conjunction with 36222-36226 as these selective codes include the work of 36221 when performed. Do not report 36222, 36223, or 36224 together for ipsilateral angiography. Instead, select the code that represents the most comprehensive service using the following hierarchy of complexity (listed in descending order of complexity): 36224>36223>36222. Do not report 36225 and 36226 together for ipsilateral angiography. Select the code that represents the more comprehensive service using the following hierarchy of complexity (listed in descending order of complexity): 36226>36225.				

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When bilateral carotid and/or vertebral arterial catheterization and imaging is performed, add modifier 50 to codes 36222-36228 if the same procedure is performed on both sides. For example, bilateral extracranial carotid angiography with selective catheterization of each common carotid artery would be reported with code 36222 and modifier 50. However, when different territory(ies) is/are studied in the same session on both sides of the body, modifiers may be required to report the imaging performed. Use modifier 59 to denote that different carotid and/or vertebral arteries are being studied. For example, selective right internal carotid artery catheterization accompanied by right extracranial and intracranial carotid angiography is followed by selective left common carotid artery catheterization with left extracranial carotid angiography, use 36224 to report the right side and 36222-59 to report the left side.

Diagnostic angiography of the cervicocerebral vessels may be followed by an interventional procedure at the same session. Interventional procedures may be separately reportable using standard coding conventions.

Do not report 75774 as part of diagnostic angiography of the extracranial and intracranial cervicocerebral vessels. It may be appropriate to report 75774 for diagnostic angiography of upper extremities and other vascular beds performed in the same session.

Report 76376 or 76377 for 3D rendering when performed in conjunction with 36221-36228.

Report 76937 for ultrasound guidance for vascular access, when performed in conjunction with 36221-36228.

36200 Introduction of catheter, aorta

(For non-selective angiography of the extracranial carotid and/or cerebral vessels and cervicocerebral arch, when performed, see 36221)

36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

(For catheter placement for coronary angiography, see 93454-93461)

36216 *initial second order thoracic or brachiocephalic branch, within a vascular family*

36217 *initial third order or more selective thoracic or brachiocephalic branch, within a vascular family*

36218 *additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)*

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(Use 36218 in conjunction with 32616 or 36217)

(For angiography, see 36147, 36222-36228, 75600-75774, 75791)

(For angioplasty, see ~~37228-37235,~~ 35471, 35472, 35475)

(For transcatheter therapies, see 37200-37208, 61624, 61626)

(When coronary artery, arterial conduit (eg, internal mammary, inferior epigastric or free radical artery) or venous bypass graft angiography is performed in conjunction with cardiac catheterization, see the appropriate cardiac catheterization, injection procedure, and imaging supervision code(s) (93455, 93457, ~~9345~~93459~~-~~, 93461, ~~93503-9353~~93530-93533, ~~93563-9356~~93564) in the~~-~~ **Medicine** section ~~of the CPT codebook. When coronary artery, arterial coronary conduit or venous bypass graft angiography is performed without concomitant left heart cardiac catheterization, see 93454-93457, 93563, 93564~~. When internal mammary artery angiography only is performed without a concomitant ~~left heart~~ cardiac catheterization, use 36216 or 36217 as appropriate.)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
⊙●36221	S1	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed (Do not report 36221 with 36222-36226)	000	4.51
⊙●36222	S2	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	000	6.00

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⦿●36223	S3	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	000	6.50
⦿●36224	S4	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	000	7.55
⦿●36225	S5	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	000	6.50
⦿●36226	S6	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	000	7.55
⦿●✚36227	S7	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) (Use 36227 in conjunction with 36222, 36223, or 36224)	ZZZ	2.32

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⊙●✚36228	S8	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure). (Use 36228 in conjunction with 36224 or 36226) (Do not report 36228 more than twice per side)	ZZZ	4.25
D75650		~~Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation~~ (Code 75650 has been deleted. To report, use 36221-36226)	XXX	N/A
D75660		~~Angiography, external carotid, unilateral, selective, radiological supervision and interpretation~~ (Code 75660 has been deleted. To report, use 36227)	XXX	N/A
D75662		~~Angiography, external carotid, bilateral, selective, radiological supervision and interpretation~~ (Code 75662 has been deleted. To report, use 36227 and append modifier 50)	XXX	N/A
D75665		~~Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation~~ (Code 75665 has been deleted. To report, see 36223, 36224)	XXX	N/A

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D75671		~~Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation~~ (Code 75671 has been deleted. To report, see 36223 and 36224 and append modifier 50)	XXX	N/A
D75676		~~Angiography, carotid, cervical, unilateral, radiological supervision and interpretation~~ (Code 75676 has been deleted. To report, see 36222-36224)	XXX	N/A
D75680		~~Angiography, carotid, cervical, bilateral, radiological supervision and interpretation~~ (Code 75680 has been deleted. To report, see 36222-36224 and append modifier 50)	XXX	N/A
D75685		~~Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation~~ (Code 75685 has been deleted. To report, see 36225, 36226)	XXX	N/A

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75774 Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)

(Use 75774 in addition to code for specific initial vessel studied.)

(Do not report 75774 as part of diagnostic angiography of the extracranial and intracranial cervicocerebral vessels. It may be appropriate to report 75774 for diagnostic angiography of upper extremities and other vascular beds performed in the same session.)

(For angiography, see 36147, 75600-75756, 75791)

(For catheterizations, see codes 36215-36248)

(For introduction of catheter, injection procedure, see 93451-93462, 93530-93533, 93563-93568)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36221 Tracking Number S1 Original Specialty Recommended RVU: **4.51**
Presented Recommended RVU: **4.51**
Global Period: 000 RUC Recommended RVU: **4.51**

CPT Descriptor: Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old male with extensive smoking history and family history of aortic aneurysmal disease presents with a six-month history of intermittent symptoms of cerebral ischemia. Ultrasound demonstrates bilateral <30% internal carotid artery stenoses, but increased velocity is noted in the left common carotid artery. A diagnostic cervicocerebral arch arteriogram is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 75%

Description of Pre-Service Work:
* A targeted H&P is performed.
* The planned procedure is discussed with the patient/family and consent is obtained for the procedure and moderate sedation.
* In the procedure room, the patient's identity and the nature of the procedure are confirmed.
* The patient is placed supine on the procedure table, monitoring equipment is attached. The head is secured. Leads and IVs are positioned away from the imaging field and out of the way of the angiographic unit. Trial rotation of the angiographic equipment is performed to ensure adequate imaging and the ability to achieve steep obliquities without patient injury or EKG lead interference. The right groin is prepared and draped in usual sterile fashion.
* Conscious sedation is administered.

Description of Intra-Service Work:
* Right common femoral arterial access is obtained and an arterial sheath placed
* A wire is inserted and a pigtail catheter is advanced over the wire retrograde into the ascending aorta.
* Test injection of contrast is performed. After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the area of interest in multiple projections to evaluate the aortic arch, great vessel origins, and cervical carotid arteries.

* The wire is reinserted and the pigtail catheter is removed
* Contrast material is injected with imaging over the common femoral artery to insure that no vessel injury, dissection, pseudoaneurysm, or significant iatrogenic vasospasm has occurred.
* The sheath is removed.
* Closure of the arteriotomy by application of an arterial closure device.

Description of Post-Service Work:
* All imaging sequences are reviewed frame by frame. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.
* Appropriate care orders are entered in the electronic medical record.
* The procedure is documented in the chart.
* A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
* The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Clifford Kavinsky, MD and Richard Wright, MD		
Specialty(s):	SIR, ACR, ASNR, SVS, AANS/CNS, ACC/SCAI, AAN		
CPT Code:	36221		
Sample Size:	6135	**Resp N:** 55	**Response:** 0.8 %
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected SVS - 1953, All US, MD members ACC/SCAI - 248 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**13.00**	64.00	333.00
Survey RVW:	2.00	4.66	**5.00**	5.90	8.10
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	20.00	**30.00**	48.00	90.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36221	**Recommended Physician Work RVU: 4.51**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**

Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36251	000	5.35	**RUC Time**

CPT Descriptor Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	108,200

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 36.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 36221**	**Key Reference CPT Code:** 36251	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	41.00	
Median Intra-Service Time	30.00	45.00	

Median Immediate Post-service Time	40.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**118.00**	**116.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	3.00
Urgency of medical decision making	3.00	2.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.74	2.63
Physical effort required	2.68	2.47
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.16	2.58
Outcome depends on the skill and judgment of physician	3.00	2.74
Estimated risk of malpractice suit with poor outcome	3.74	3.26

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.65
Intra-Service intensity/complexity	2.90	2.75
Post-Service intensity/complexity	2.80	2.70

Additional Rationale and Comments

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

Preamble

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup.

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address complex clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Post Time

Carotid and cerebral angiography are performed as a problem solving procedure in patients with complex atherosclerotic carotid and companion cerbrovascular disease, work-up of intra- and extracranial tumors, and vasculopathies. The number or main vessels, multitude of small caliber *named* branch vessels, clinically important potential collateral pathways, and additionally complex venous anatomy translate to a 3-6 fold increase in the the: number of necessary angiographic runs (each with 10-60 frames/second), intensity of cognitive interpretation, and physician effort and time. The multi-disciplinary expert panel realizes this significant effort and that it was not reflected in the responses of our survey respondents. We believe this is due to their lack of understanding of the post-service period as suggested by exactly similar response times for all 8 codes. We believe that 40 minutes of post service time more accurately reflects the additional work involved.

Survey Results

A multi-specialty survey of 55 respondents yielded a median wRVU of 5.00 and median intra-procedural time of 30 minutes. 84% of the survey respondents found the vignette to be typical. Maintenance of the current wRVU 4.51 is recommended for 36221 although the expert panel believes that noninvasive imaging is utilized for straightforward patients and now results in a change of the overall patient population undergoing catheter cerebral angiography who are inherently a more complex patient population.

Pre Time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. 91% of the survey respondents found CS to be typical in the facility setting. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure (including securing the head), and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary AP, oblique and lateral views involved with the complex nature of the intra- and extra- cranial vasculature. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

The key reference service chosen was 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (wRVU 5.35, intra- time of 45, total time 116).

This is similar to 36221 in the sense that they are both diagnostic angiographic procedures. The reference service involves shorter catheters and abdominal imaging in the AP projection as well as a selective first order vessel catheterization thus accounting for the additional 10 minutes in intra- time. 36221 involves longer catheters without additional selectivity, however, does involve a more complex clinical scenario with significant increased patient risk (stroke). Additionally the involved anatomy demonstrates more tortuosity and cardiac motion compared to the referenced code and more (numerical) vessels are evaluated in the surveyed code requiring a greater number of views and interpretive effort.

Given these similarities and differences, the two codes compare favorably and support our recommended wRVU 4.51 (current value). In addition, the recommendation for 36221 lines up nicely with several other codes. See below:

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36221	4.51	0.087	118	40	3	5	30	40
37191	4.71	0.1198	83	30	3	5	30	15
93452	4.75	0.1025	108	40	3	5	30	30
93454	4.79	0.1038	108	40	3	5	30	30
36251	5.35	0.085	116	33	3	5	45	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to attached budget neutrality table for information on previous reporting.

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

Specialty Vascular Surgery How often? Commonly

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,600
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Plase refer to the attached budget neutrality table for information on previous reporting.

Specialty Vascular Surgery Frequency 1066 Percentage 41.00 %

Specialty Cardiology Frequency 468 Percentage 18.00 %

Specialty Radiology Frequency 442 Percentage 17.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36200

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36222 Tracking Number S2 Original Specialty Recommended RVU: **6.00**
Presented Recommended RVU: **6.00**
Global Period: 000 RUC Recommended RVU: **6.00**

CPT Descriptor: Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old male with a prior right carotid endarterectomy three years ago presents with ultrasound evidence for a >80% asymptomatic internal carotid artery restenosis. A diagnostic carotid arteriogram is requested.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 82%

Description of Pre-Service Work:
• A targeted H&P is performed.
• The planned procedure is discussed with the patient/family and consent is obtained for the procedure and moderate sedation.
• In the procedure room, the patient's identity and the nature of the procedure are confirmed.
• The patient is placed supine on the procedure table and monitoring equipment is attached. The head is secured. Leads and IVs are positioned away from the field of interest and out of the way of the C-arm. The equipment is tested to assure attainability of desired obliquities. The right groin is prepared and draped in usual sterile fashion.
• Conscious sedation is administered.

Description of Intra-Service Work:

• Right common femoral arterial access is obtained and an arterial sheath placed
• A wire is inserted and a pigtail catheter is advanced over the wire retrograde into the ascending aorta. Test injection of contrast is performed.

• After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the area of interest in multiple projections to evaluate the aortic arch, great vessel origins, and cervical carotid arteries.
• A guidewire is placed into the indwelling diagnostic pigtail catheter. This catheter is removed over a wire.
• The guidewire and catheter combination are advanced selectively under realtime fluoroscopic guidance as well as road map imaging first into the innominate artery followed by the right common carotid artery. The guidewire is removed.
• A test injection of contrast is performed. After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the area of interest in the extracranial carotid territory, using multiple projections.
• The selective catheter is removed
• Contrast material is injected with imaging over the common femoral artery to insure that no vessel injury, dissection, pseudoaneurysm, or significant iatrogenic vasospasm has occurred.
• The sheath is removed.
• Closure of the arteriotomy by pressure or application of an arterial closure device, as appropriate

Description of Post-Service Work:
• All imaging sequences are reviewed frame by frame. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.
• Appropriate care orders are entered in the electronic medical record.
• The procedure is documented in the chart.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Henry Woo, MD, Clifford Kavinsky, MD and Richard Wright, MD		
Specialty(s):	SIR, ACR, ASNR, SVS, AANS/CNS, ACC/SCAI, AAN		
CPT Code:	36222		
Sample Size:	6135	**Resp N:** 55	**Response:** 0.8 %
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected SVS - 1953, All US, MD members ACC/SCAI - 248 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**20.00**	100.00	400.00
Survey RVW:	3.00	5.53	**6.00**	8.00	10.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	30.00	**40.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36222	**Recommended Physician Work RVU: 6.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**

Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36251	000	5.35	**RUC Time**

CPT Descriptor Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 34.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 36222**	**Key Reference CPT Code:** 36251	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	41.00	
Median Intra-Service Time	40.00	45.00	

Median Immediate Post-service Time	40.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**128.00**	**116.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.16	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.32	3.16
Urgency of medical decision making	3.37	3.16
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.47	3.21
Physical effort required	3.00	2.89
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.79	3.32
Outcome depends on the skill and judgment of physician	3.74	3.53
Estimated risk of malpractice suit with poor outcome	4.16	3.68

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.89	2.68
Intra-Service intensity/complexity	3.42	3.16
Post-Service intensity/complexity	2.83	2.78

Additional Rationale and Comments

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

Preamble

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup.

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address complex clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Post Time

Carotid and cerebral angiography are performed as a problem solving procedure in patients with complex atherosclerotic carotid and companion cerbrovascular disease, work-up of intra- and extracranial tumors, and vasculopathies. The number or main vessels, multitude of small caliber *named* branch vessels, clinically important potential collateral pathways, and additionally complex venous anatomy translate to a 3-6 fold increase in the the: number of necessary angiographic runs (each with 10-60 frames/second), intensity of cognitive interpretation, and physician effort and time. The multi-disciplinary expert panel realizes this significant effort and that it was not reflected in the responses of our survey respondents. We believe this is due to their lack of understanding of the post-service period as suggested by exactly similar response times for all 8 codes. We believe that 40 minutes of post service time more accurately reflects the additional work involved.

Survey Results

A multi-specialty survey of 55 respondents yielded a median wRVU of 6.00 and a median intra-procedural time of 40 minutes. 96% of the survey respondents found the vignette to be typical. The expert panel recommends the median surveyed wRVU of 6.00.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. 89% of the survey respondents found CS to be typical in the facility setting. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure (including securing the head), and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views involved with the complex nature of the intra- and extra- cranial vasculature. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

The key reference service chosen was 36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (wRVU 5.35, intra- time of 45, total time 116).

This is similar to 36236222 in the sense that they are both diagnostic angiographic procedures. The reference service involves shorter catheters and abdominal imaging as well as a selective first order vessel catheterization. 36236222 involves longer catheters in addition to a second order vessel catheterization. The aortic arch, braciocephalic artery, and common carotid artery are typically more tortuous requiring more work in the opinion of the multidisciplinary expert panel. Additionally there is increased stroke risk. Overall, the expert panel and the surveyed respondents (true?) found 36236222 to be of greater complexity than the key reference code. Therefore it is unclear why the median time value for the surveyed code was 5 minutes less than the key reference.

Despite these similarities and differences, the two codes compare reasonably. Although time comparisons are not exact, the expert panel believes that since 36236222 involves a more selective vessel catheterization and increased risk, the median wRVU 6.00 is supported and maintains rank order with a similar diagnostic angiographic code.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36236222	6.00	0.103	128	40	3	5	40	40
36251	5.35	0.085	116	33	3	5	45	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to attached budget neutrality table for information on previous reporting

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

Specialty Radiology How often? Commonly

Specialty Cardiology How often? Commonly

Specialty NeuroSurgery How often? Commonly

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
30,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached budget neutrality table for information on previous reporting

Specialty Radiology	Frequency 9600	Percentage 32.00 %
Specialty Cardiology	Frequency 7500	Percentage 25.00 %
Specialty NeuroSurgery	Frequency 3900	Percentage 13.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36216

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36223 Tracking Number S3 Original Specialty Recommended RVU: **6.50**
Presented Recommended RVU: **6.50**
Global Period: 000 RUC Recommended RVU: **6.50**

CPT Descriptor: Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old female presents with complaints of left upper extremity numbness and weakness, symptoms of right cerebral TIA, and ultrasound documentation of right internal carotid artery 70% stenosis. A diagnostic cerebral arteriogram is requested.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

Description of Pre-Service Work:
• A targeted H&P is performed.
• The planned procedure is discussed with the patient/family and consent is obtained for the procedure and moderate sedation.
• In the procedure room, the patient's identity and the nature of the procedure are confirmed.
• The patient is placed supine on the procedure table and monitoring equipment is attached. The head is secured. Leads and IVs are positioned away from the field of interest and out of the way of the C-arm. The equipment is tested to assure attainability of desired obliquities. The right groin is prepared and draped in usual sterile fashion.
• Conscious sedation is administered

Description of Intra-Service Work:
• Right common femoral arterial access is obtained and an arterial sheath placed
• A wire is inserted and a pigtail catheter is advanced over the wire retrograde into the ascending aorta. Test injection of contrast is performed.
• After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the area of interest in multiple projections to evaluate the aortic arch, great vessel origins, and cervical carotid arteries.
• A guide wire is introduced through the pigtail catheter and the catheter is exchanged for a selective catheter.

• The selective catheter is guided into the right common carotid artery under real time fluoroscopic guidance and/or roadmap imaging guidance using either guide wire technique or contrast puff technique.
• A test injection of contrast is performed. After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the areas of interest. Multiple contrast injections are made and digital subtraction imaging of the cervical and intracranial carotid distributions is acquired in AP, oblique, and lateral projections. If necessary, oblique views are obtained to profile the carotid bifurcation and the intracranial pathology.
• The selective catheter is removed
• Contrast material is injected with imaging over the common femoral artery to insure that no vessel injury, dissection, pseudoaneurysm, or significant iatrogenic vasospasm has occurred.
• The sheath is removed.
• Closure of the arteriotomy by pressure or application of an arterial closure device, as appropriate

Description of Post-Service Work:
•All imaging sequences are reviewed frame by frame. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.
• Appropriate care orders are entered in the electronic medical record.
• The procedure is documented in the chart.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Henry Woo, MD, Clifford Kavinsky, MD and Richard Wright, MD		
Specialty(s):	SIR, ACR, ASNR, SVS, AANS/CNS, ACC/SCAI, AAN		
CPT Code:	36223		
Sample Size:	6135	**Resp N:** 55	**Response:** 0.8 %
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected SVS - 1953, All US, MD members ACC/SCAI - 248 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	7.00	**35.00**	135.00	400.00
Survey RVW:	4.00	6.00	**7.00**	8.05	10.50
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36223	**Recommended Physician Work RVU: 6.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**

Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36253	000	7.55	**RUC Time**

CPT Descriptor Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 32.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 36223**	**Key Reference CPT Code:** 36253	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	41.00	
Median Intra-Service Time	45.00	60.00	

Median Immediate Post-service Time	40.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**133.00**	**131.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.39	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.28
Urgency of medical decision making	3.33	3.17
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.76	3.65
Physical effort required	3.18	3.12
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.88	3.18
Outcome depends on the skill and judgment of physician	4.00	3.47
Estimated risk of malpractice suit with poor outcome	4.06	3.35

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	2.94
Intra-Service intensity/complexity	3.72	3.33
Post-Service intensity/complexity	2.94	2.89

Additional Rationale and Comments

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

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There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

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- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Post Time

Carotid and cerebral angiography are performed as a problem solving procedure in patients with complex atherosclerotic carotid and companion cerbrovascular disease, work-up of intra- and extracranial tumors, and vasculopathies. The number or main vessels, multitude of small caliber *named* branch vessels, clinically important potential collateral pathways, and additionally complex venous anatomy translate to a 3-6 fold increase in the the: number of necessary angiographic runs (each with 10-60 frames/second), intensity of cognitive interpretation, and physician effort and time. The multi-disciplinary expert panel realizes this significant effort and that it was not reflected in the responses of our survey respondents. We believe this is due to their lack of understanding of the post-service period as suggested by exactly similar response times for all 8 codes. We believe that 40 minutes of post service time more accurately reflects the additional work involved.

36223/36225 Preamble

The expert panel believes that there are significant similarities between 36236223 and 36236225; Both diagnostic angiographic codes involve second or third order cervico-cerebral vessel selection. Furthermore both codes involve extensive angiography. Multiple S&I codes are now bundled with the corresponding surgical codes to describe this work. Specifically in addition to arch aortography, this new code now also includes 2 DSA runs of the extra-cranial circulation in addition to 3 DSA runs of intra-cranial circulation. Based on the significant changes compared to current coding convention, survey respondents may not have completely understood the ramifications of code bundling. Survey respondents reported similar median intra-service times of 45 minutes for each code and the expert panel will recommend median value of 36225 (wRVU 6.50) for both codes.

Survey Results

A multi-specialty survey of 55 respondents yielded a median wRVU of 7.00 (25th percentile, wRVU 6.00) and median intra-procedural time of 45 minutes. 95% of the survey respondents found the vignette to be typical. After considerable discussions considering magnitude estimation both within this family and other related families, the expert panel recommends for 36236223 the median surveyed for the similar code within this family 36236225: wRVU of 6.50.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. 89% of the survey respondents found CS to be typical in the facility setting. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure (including securing the head), and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views involved with the

complex nature of the intra- and extra- cranial vasculature. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

The key reference service chosen was 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (wRVU 7.55, intra- time 60 minutes, total time 131).

This is similar to 36236223 in the sense that they are both diagnostic angiographic procedures. The reference service involves shorter catheters and abdominal imaging as well as a sub-selective second order (or higher) vessel catheterization. 36236223 involves longer catheters as well as second or third order sub-selective vessel catheterization. The aortic arch, braciocephalic artery, and common carotid artery are typically more tortuous requiring more work in the opinion of the multidisciplinary expert panel. Additionally there is increased stroke risk and significantly more imaging. Overall, the expert panel and the surveyed respondents (true?) found 36236223 to be of greater complexity than the key reference code. Therefore it is unclear why the median time value for the surveyed code was 15 minutes less than the key reference unless the respondents did not understand the full impact of significant code bundling.

Despite these similarities and differences, the two codes compare reasonably. Although time comparisons are not exact, the expert panel believes that since 36236223 involves a similar degree of selective vessel catheterization, increased imaging, and increased risk, the median 36225 wRVU 6.50 is supported and maintains rank order within this code family and similar diagnostic angiographic code families.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36236223	6.50	0.102	133	40	3	5	45	40
36253	7.55	0.101	131	33	3	5	60	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to attached budget neutrality table for information on previous reporting.

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

Specialty Radiology How often? Commonly

Specialty Cardiology How often? Commonly

Specialty NeuroSurgery How often? Commonly

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached budget neutrality table for information on previous reporting.

Specialty Radiology Frequency 12800 Percentage 32.00 %

Specialty Cardiology Frequency 10000 Percentage 25.00 %

Specialty NeuroSurgery Frequency 5200 Percentage 13.00 %

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

Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36216

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36224 Tracking Number S4 Original Specialty Recommended RVU: **7.55**
Presented Recommended RVU: **7.55**
Global Period: 000 RUC Recommended RVU: **7.55**

CPT Descriptor: Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male has sudden onset of severe headache with a brief period of unconsciousness. A CT scan shows diffuse subarachnoid hemorrhage in the basal cisterns suspicious for an anterior communicating artery aneurysm. A diagnostic cerebral arteriogram is requested.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 88%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

Description of Pre-Service Work:
• A targeted H&P is performed.
• The planned procedure is discussed with the patient/family and consent is obtained for the procedure and moderate sedation.
• In the procedure room, the patient's identity and the nature of the procedure are confirmed.
• The patient is placed supine on the procedure table, monitoring equipment is attached, and the femoral region is prepared and draped in usual sterile fashion.
• Conscious sedation is administered.

Description of Intra-Service Work:
• Right common femoral arterial access is obtained and an arterial sheath placed
• A wire is inserted and a pigtail catheter is advanced over the wire retrograde into the ascending aorta.
• Contrast is injected through the catheter with digital subtraction imaging over the area of interest in multiple projections to evaluate the aortic arch, great vessel origins, and cervical carotid arteries.
• A guide wire is introduced through the pigtail catheter and the catheter is exchanged for a selective catheter.
• The selective catheter is guided into the right common carotid artery under fluoroscopic guidance
• Multiple contrast material injections are made and digital imaging of the cervical carotid distribution is acquired in AP, oblique, and lateral projections.

• A steerable guidewire is inserted and the catheter is advanced into the internal carotid artery over the guidewire under fluoroscopic guidance.
• Multiple contrast material injections are made and digital imaging of the intracranial carotid distribution is acquired in AP, oblique, and lateral projections into the arterial, capillary and venous phases.
• Contrast material is injected with imaging over the common femoral artery to insure that no vessel injury, dissection, pseudoaneurysm, or significant iatrogenic vasospasm has occurred.
• The sheath is removed.
• Closure of the arteriotomy by pressure or application of an arterial closure device, as appropriate

Description of Post-Service Work:
• All imaging sequences are reviewed frame by frame. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.
• Appropriate care orders are entered in the electronic medical record.
• The procedure is documented in the chart.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Henry Woo, MD, Clifford Kavinsky, MD and Richard Wright, MD				
Specialty(s):	SIR, ACR, ASNR, AANS/CNS, ACC/SCAI, AAN				
CPT Code:	36224				
Sample Size:	4182	**Resp N:**	43	**Response:** 1.0 %	
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected ACC/SCAI - 248 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**50.00**	150.00	400.00
Survey RVW:	4.00	6.50	**8.00**	9.00	11.50
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	36.00	**50.00**	60.00	135.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36224	**Recommended Physician Work RVU: 7.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**

Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36253	000	0.00	**RUC Time**

CPT Descriptor Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 1 Tracheostomy, planned (separate procedure);

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43269	000	8.20	**RUC Time**	19,974

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 41.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 36224**	**Key Reference CPT Code:** 36253	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	41.00	
Median Intra-Service Time	50.00	60.00	
Median Immediate Post-service Time	40.00	30.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**138.00**	**131.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.17
Urgency of medical decision making	4.17	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.11	3.61
Physical effort required	3.56	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.28	3.28
Outcome depends on the skill and judgment of physician	4.28	3.67
Estimated risk of malpractice suit with poor outcome	4.17	3.72

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.17	2.89
Intra-Service intensity/complexity	3.89	3.44
Post-Service intensity/complexity	3.06	3.00

Additional Rationale and Comments

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

Preamble

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup.

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address complex clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA

angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Post Time

Carotid and cerebral angiography are performed as a problem solving procedure in patients with complex atherosclerotic carotid and companion cerbrovascular disease, work-up of intra- and extracranial tumors, and vasculopathies. The number or main vessels, multitude of small caliber *named* branch vessels, clinically important potential collateral pathways, and additionally complex venous anatomy translate to a 3-6 fold increase in the the: number of necessary angiographic runs (each with 10-60 frames/second), intensity of cognitive interpretation, and physician effort and time. The multi-disciplinary expert panel realizes this significant effort and that it was not reflected in the responses of our survey respondents. We believe this is due to their lack of understanding of the post-service period as suggested by exactly similar response times for all 8 codes. We believe that 40 minutes of post service time more accurately reflects the additional work involved.

36224/36226 Preamble

The expert panel believes that there are significant similarities between 36236224 and 36236226; Both diagnostic angiographic codes involve second or third order cervico-cerebral vessel selection. Furthermore both codes involve extensive angiography. Multiple S&I codes are now bundled with the corresponding surgical codes to describe this work. Specifically in addition to arch aortography, this new code now also includes at a minimum and AP and lateral projections of the extra-cranial circulation. The catheter is then navigated into a higher order vessel that is smaller in caliber and primarily supplies central nervous system structures. These factors significantly increase the risk of vessel injury and dissection and subsequently increase the risk of stroke. AP and lateral projections of the intracranial circulation are obtained and depending on the pathology multiple oblique projections at possibly higher frame rate acquisitions will also be obtained. These images also require immediate preliminary interpretation to confirm that the relevant imaging has been acquired. Based on the significant changes compared to current coding convention, survey respondents may not have completely understood the ramifications of code bundling. Survey respondents reported similar median intra-service times of 50 minutes for each code and the expert panel will recommend below median value of 36224 and 36226 (wRVU 7.55) for both codes.

Survey Results

A multi-specialty survey of 55 respondents yielded a median of 8.00 (25th percentile, wRVU 6.50) and median intra-procedural time was 50 minutes. 88% of the survey respondents found the vignette to be typical. After considerable discussions considering magnitude estimation both within this family and other related families, the expert panel recommends for 36236224 the below median surveyed for 36236224 and the similar code within this family 36236226: wRVU of 7.55.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. 88% of the survey respondents found CS to be typical in the facility setting. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure

(including securing the head), and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views involved with the complex nature of the intra- and extra- cranial vasculature. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

The key reference service chosen was 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (wRVU 7.55, intra- time 60 minutes, total time 131).

This is similar to 36236224 in the sense that they are both diagnostic angiographic procedures. The reference service involves shorter catheters and abdominal imaging as well as a sub-selective second order (or higher) vessel catheterization. 36236224 involves longer catheters as well as second or third order sub-selective vessel catheterization. The aortic arch, braciocephalic artery, common and internal carotid arteries are typically more tortuous requiring more work in the opinion of the multidisciplinary expert panel. Additionally there is increased stroke risk secondary to the smaller caliber of vessels being catheterized whose primary outflow leads essentially solely into the central nervous system. There is also significantly more imaging secondary to the complexity of cerebrovascular disorders. Overall, the expert panel and the surveyed respondents found 36236224 to be of greater complexity than the key reference code. The intensity measures were all more complex for the surveyed code compared to the reference code. Given the level of intensity, it is unclear why the median time value for the surveyed code was 10 minutes less than the key reference unless the respondents did not understand the full impact of significant code bundling. Despite the 10 minutes intra-procedural time difference, the expert panel felt the intensity factor more than accounted for the time difference.

Despite these similarities and differences, the two codes compare reasonably. Although time comparisons are not exact, the expert panel believes that since 36236224 involves a similar degree of selective vessel catheterization, increased imaging, and increased risk. The expert panel believes wRVU 7.55 is supported and maintains rank order within this code family and similar diagnostic angiographic code families.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36236224	7.55	0.113	138	40	3	5	50	40
36253	7.55	0.101	131	33	3	5	60	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to attached budget neutrality table for information on previous reporting.

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

Specialty Radiology How often? Commonly

Specialty NeuroSurgery How often? Commonly

Specialty Cardiology How often? Commonly

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
40,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached budget neutrality table for information on previous reporting.

Specialty Radiology Frequency 21600 Percentage 54.00 %

Specialty NeuroSurgery Frequency 7200 Percentage 18.00 %

Specialty Cardiology Frequency 4800 Percentage 12.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36217

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36225 Tracking Number S5 Original Specialty Recommended RVU: **6.50**
Presented Recommended RVU: **6.50**
Global Period: 000 RUC Recommended RVU: **6.50**

CPT Descriptor: Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old man presents with a recent posterior circulation stroke. A diagnostic vertebral arteriogram is requested.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

Description of Pre-Service Work:
• A targeted H&P is performed.
• The planned procedure is discussed with the patient/family and consent is obtained for the procedure and moderate sedation.
• In the procedure room, the patient's identity and the nature of the procedure are confirmed.
• The patient is placed supine on the procedure table and monitoring equipment is attached. The head is secured. Leads and IVs are positioned away from the field of interest and out of the way of the C-arm. The equipment is tested to assure attainability of desired obliquities. The right groin is prepared and draped in usual sterile fashion.
• Conscious sedation is administered.

Description of Intra-Service Work:
• Right common femoral arterial access is obtained and an arterial sheath placed
• A wire is inserted and a pigtail catheter is advanced over the wire retrograde into the ascending aorta. Test injection of contrast is performed.
• After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the area of interest in multiple projections to evaluate the aortic arch, great vessel origins, and cervical carotid arteries.
• A guide wire is introduced through the pigtail catheter and the catheter is exchanged for a selective catheter.
• The selective catheter is guided into the right subclavian artery under real time fluoroscopic guidance and/or roadmap imaging guidance using either guide wire technique or contrast puff technique.

• A test injection of contrast is performed. After all tubing is checked to ensure that no air bubbles or blood products are present, contrast is injected through the catheter with digital subtraction imaging over the areas of interest. Multiple contrast injections are made and digital subtraction imaging of the cervical and intracranial vertebrobasilar distributions is acquired in AP, oblique, and lateral projections. If necessary, oblique views are obtained to profile the vertebral origin and the intracranial pathology.
• The selective catheter is removed
• Contrast material is injected with imaging over the common femoral artery to insure that no vessel injury, dissection, pseudoaneurysm, or significant iatrogenic vasospasm has occurred.
• The sheath is removed.
• Closure of the arteriotomy by pressure or application of an arterial closure device, as appropriate

Description of Post-Service Work:
• All imaging sequences are reviewed frame by frame. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.
• Appropriate care orders are entered in the electronic medical record.
• The procedure is documented in the chart.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Henry Woo, MD, Clifford Kavinsky, MD and Richard Wright, MD		
Specialty(s):	SIR, ACR, ASNR, SVS, AANS/CNS, ACC/SCAI, AAN		
CPT Code:	36225		
Sample Size:	6135	**Resp N:** 55	**Response:** 0.8 %
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected SVS - 1953, All US, MD members ACC/SCAI - 248 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	90.00	400.00
Survey RVW:	3.00	5.60	**6.50**	8.05	12.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	18.00	30.00	**45.00**	60.00	105.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36225	**Recommended Physician Work RVU: 6.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**

Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36251	000	5.35	**RUC Time**

CPT Descriptor Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 32.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 36225**	**Key Reference CPT Code:** 36251	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	41.00	
Median Intra-Service Time	45.00	45.00	

Median Immediate Post-service Time	40.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**133.00**	**116.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.88	2.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	2.94
Urgency of medical decision making	3.24	2.82
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.18	2.88
Physical effort required	2.76	2.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.29	2.82
Outcome depends on the skill and judgment of physician	3.47	3.24
Estimated risk of malpractice suit with poor outcome	3.88	3.35

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.82	2.59
Intra-Service intensity/complexity	3.29	3.06
Post-Service intensity/complexity	2.63	2.56

Additional Rationale and Comments

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

Preamble

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup.

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address complex clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Post Time

Carotid and cerebral angiography are performed as a problem solving procedure in patients with complex atherosclerotic carotid and companion cerbrovascular disease, work-up of intra- and extracranial tumors, and vasculopathies. The number or main vessels, multitude of small caliber *named* branch vessels, clinically important potential collateral pathways, and additionally complex venous anatomy translate to a 3-6 fold increase in the the: number of necessary angiographic runs (each with 10-60 frames/second), intensity of cognitive interpretation, and physician effort and time. The multi-disciplinary expert panel realizes this significant effort and that it was not reflected in the responses of our survey respondents. We believe this is due to their lack of understanding of the post-service period as suggested by exactly similar response times for all 8 codes. We believe that 40 minutes of post service time more accurately reflects the additional work involved.

36223/36225 Preamble

The expert panel believes that there are significant similarities between 36236223 and 36236225; Both diagnostic angiographic codes involve second or third order cervico-cerebral vessel selection. Furthermore both codes involve extensive angiography. Multiple S&I codes are now bundled with the corresponding surgical codes to describe this work. Specifically in addition to arch aortography, this new code now also includes 2 DSA runs of the extra-cranial circulation in addition to 3 DSA runs of intra-cranial circulation. Based on the significant changes compared to current coding convention, survey respondents may not have completely understood the ramifications of code bundling. Survey respondents reported similar median intra-service times of 45 minutes for each code and the expert panel will recommend median value of 36225 (wRVU 6.50) for both codes.

Survey Results

A multi-specialty survey of 55 respondents yielded a median wRVU of 6.50 (25th percentile, wRVU 5.60) and median intra-procedural time was 45 minutes. 85% of the survey respondents found the vignette to be typical. After considerable discussions considering magnitude estimation both within this family and other related families, the expert panel recommends the median surveyed of 36236225: wRVU of 6.50.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. 89% of the survey respondents found CS to be typical in the facility setting. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure (including securing the head), and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views involved with the

complex nature of the intra- and extra- cranial vasculature. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

The key reference service chosen was 36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (wRVU 5.35, intra- time of 45, total time 116).

This is similar to 36236225 in the sense that they are both diagnostic angiographic procedures. The reference service involves shorter catheters and abdominal imaging and a first order vessel catheterization. 36236225 involves longer catheters as well as a first or second order cervico-cerebral vessel catheterization. The aortic arch, braciocephalic artery, and common carotid artery are typically more tortuous requiring more work in the opinion of the multidisciplinary expert panel. Additionally there is increased stroke risk and significantly more imaging. Overall, the expert panel and the surveyed respondents (true?) found 36236225 to be of greater complexity than the key reference code. Therefore it is unclear why the median time value for the surveyed code was similar to the key reference unless the respondents did not understand the full impact of significant code bundling.

Despite these similarities and differences, the two codes compare reasonably. Although times are similar, the expert panel believes that since 36236225 involves a similar or greater degree of selective vessel catheterization, increased imaging, and increased risk, the median wRVU 6.50 is supported and maintains rank order within this code family and similar diagnostic angiographic code families.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36236225	6.50	0.102	133	40	3	5	45	40
36251	5.35	0.085	116	33	3	5	45	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to attached budget neutrality table for information on previous reporting.

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

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

Specialty Vascular Surgery How often? Commonly

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
30,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached budget neutrality table for information on previous reporting.

Specialty Cardiology Frequency 13200 Percentage 44.00 %

Specialty Radiology Frequency 8400 Percentage 28.00 %

Specialty Vascular Surgery Frequency 4500 Percentage 15.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36215

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36226 Tracking Number S6 Original Specialty Recommended RVU: **7.55**
Presented Recommended RVU: **7.55**
Global Period: 000 RUC Recommended RVU: **7.55**

CPT Descriptor: Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old woman has sudden onset of severe headache with a brief period of unconsciousness. A CT scan shows third ventricular hemorrhage and subarachnoid hemorrhage. A diagnostic vertebral arteriogram is requested.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

Description of Pre-Service Work:
• A targeted H&P is performed.
• The planned procedure is discussed with the patient/family and consent is obtained for the procedure and moderate sedation.
• In the procedure room, the patient's identity and the nature of the procedure are confirmed.
• The patient is placed supine on the procedure table, monitoring equipment is attached, and the right groin is prepared and draped in usual sterile fashion.
• Conscious sedation is administered.

Description of Intra-Service Work:
• Right common femoral arterial access is obtained and an arterial sheath placed
• A wire is inserted and a pigtail catheter is advanced over the wire retrograde into the ascending aorta.
• Contrast is injected through the catheter with digital subtraction imaging over the area of interest in multiple projections to evaluate the aortic arch, great vessel origins, and cervical carotid arteries.
• A guide wire is introduced through the pigtail catheter and the catheter is exchanged for a selective catheter.
• The selective catheter and guidewire combination are guided into the right subclavian artery under fluoroscopic guidance.
• Multiple contrast material injections are made and digital imaging of the cervical vertebral artery distribution is acquired in multiple projections.

• A steerable guidewire is inserted and the catheter is advanced into the right vertebral artery over the guidewire under fluoroscopic guidance.
• Multiple contrast material injections are made and digital imaging of the intracranial vertebral artery distribution is acquired in AP, oblique, and lateral projections in arterial, capillary, and venous phases.
• The selective catheter is removed
• Contrast material is injected with imaging over the common femoral artery to insure that no vessel injury, dissection, pseudoaneurysm, or significant iatrogenic vasospasm has occurred.
• The sheath is removed.
• Closure of the arteriotomy by pressure or application of an arterial closure device, as appropriate

Description of Post-Service Work:
• All imaging sequences are reviewed frame by frame. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.
• Appropriate care orders are entered in the electronic medical record.
• The procedure is documented in the chart.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Henry Woo, MD, Clifford Kavinsky, MD and Richard Wright, MD				
Specialty(s):	SIR, ACR, ASNR, AANS/CNS, ACC/SCAI, AAN				
CPT Code:	36226				
Sample Size:	4182	**Resp N:**	43	**Response:** 1.0 %	
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected ACC/SCAI - 248 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	7.00	**50.00**	150.00	400.00
Survey RVW:	5.50	7.25	**8.00**	9.00	11.50
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	35.00	**50.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36226	**Recommended Physician Work RVU: 7.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**

Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36253	000	7.55	**RUC Time**

CPT Descriptor Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 1 Tracheostomy, planned (separate procedure);

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43269	000	8.20	**RUC Time**	19,974

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 41.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 36226**	**Key Reference CPT Code:** 36253	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	41.00	
Median Intra-Service Time	50.00	60.00	
Median Immediate Post-service Time	40.00	30.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**138.00**	**131.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.72	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.28
Urgency of medical decision making	4.06	3.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.11	3.61
Physical effort required	3.56	3.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	3.17
Outcome depends on the skill and judgment of physician	4.50	3.78
Estimated risk of malpractice suit with poor outcome	4.24	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.22	3.06
Intra-Service intensity/complexity	4.28	3.78
Post-Service intensity/complexity	2.88	2.82

Additional Rationale and Comments

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

Preamble

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup.

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address complex clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA

angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Post Time

Carotid and cerebral angiography are performed as a problem solving procedure in patients with complex atherosclerotic carotid and companion cerbrovascular disease, work-up of intra- and extracranial tumors, and vasculopathies. The number or main vessels, multitude of small caliber *named* branch vessels, clinically important potential collateral pathways, and additionally complex venous anatomy translate to a 3-6 fold increase in the the: number of necessary angiographic runs (each with 10-60 frames/second), intensity of cognitive interpretation, and physician effort and time. The multi-disciplinary expert panel realizes this significant effort and that it was not reflected in the responses of our survey respondents. We believe this is due to their lack of understanding of the post-service period as suggested by exactly similar response times for all 8 codes. We believe that 40 minutes of post service time more accurately reflects the additional work involved.

36224/36226 Preamble

The expert panel believes that there are significant similarities between 36236224 and 36236226; Both diagnostic angiographic codes involve second or third order cervico-cerebral vessel selection. Furthermore both codes involve extensive angiography. Multiple S&I codes are now bundled with the corresponding surgical codes to describe this work. Specifically in addition to arch aortography, this new code now also includes at a minimum and AP and lateral projections of the extra-cranial circulation. The catheter is then navigated into a higher order vessel that is smaller in caliber and primarily supplies central nervous system structures. These factors significantly increase the risk of vessel injury and dissection and subsequently increase the risk of stroke. AP and lateral projections of the intracranial circulation are obtained and depending on the pathology multiple oblique projections at possibly higher frame rate acquisitions will also be obtained. These images also require immediate preliminary interpretation to confirm that the relevant imaging has been acquired. Based on the significant changes compared to current coding convention, survey respondents may not have completely understood the ramifications of code bundling. Survey respondents reported similar median intra-service times of 50 minutes for each code and the expert panel will recommend below median value of 36224 and 36226 (wRVU 7.55) for both codes.

Survey Results

A multi-specialty survey of 55 respondents yielded a median of 8.00 (25th percentile, wRVU 7.25) and median intra-procedural time was 50 minutes. 86% of the survey respondents found the vignette to be typical. After considerable discussions considering magnitude estimation both within this family and other related families, the expert panel recommends for 36236226 the below median surveyed for 36236226 and the similar code within this family 36236224: wRVU of 7.55.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. 91% of the survey respondents found CS to be typical in the facility setting. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure

(including securing the head), and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views involved with the complex nature of the intra- and extra- cranial vasculature. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

The key reference service chosen was 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (wRVU 7.55, intra- time 60 minutes, total time 131).

This is similar to 36236226 in the sense that they are both diagnostic angiographic procedures. The reference service involves shorter catheters and abdominal imaging as well as a sub-selective second order (or higher) vessel catheterization. 36236226 involves longer catheters as well as second or third order sub-selective vessel catheterization. The aortic arch, braciocephalic artery, subclavian artery and vertebral arteries are typically more tortuous requiring more work in the opinion of the multidisciplinary expert panel. Additionally there is increased stroke risk secondary to the smaller caliber of vessels being catheterized whose primary outflow leads essentially solely into the central nervous system. There is also significantly more imaging secondary to the complexity of cerebrovascular disorders. Overall, the expert panel and the surveyed respondents found 36236226 to be of greater complexity than the key reference code. The intensity measures were all more complex for the surveyed code compared to the reference code. Given the level of intensity, it is unclear why the median time value for the surveyed code was 10 minutes less than the key reference unless the respondents did not understand the full impact of significant code bundling. Despite the 10 minutes intra-procedural time difference, the expert panel felt the intensity factor more than accounted for the time difference.

Despite these similarities and differences, the two codes compare reasonably. Although time comparisons are not exact, the expert panel believes that since 36236226 involves a similar degree of selective vessel catheterization, increased imaging, and increased risk. The expert panel believes wRVU 7.55 is supported and maintains rank order within this code family and similar diagnostic angiographic code families.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36236226	7.55	0.113	138	40	3	5	50	40
36253	7.55	0.101	131	33	3	5	60	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to attached budget neutrality table for information on previous reporting.

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

Specialty Radiology How often? Commonly

Specialty NeuroSurgery How often? Commonly

Specialty Cardiology How often? Commonly

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
13,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached budget neutrality table for information on previous reporting.

Specialty Radiology Frequency 8320 Percentage 64.00 %

Specialty NeuroSurgery Frequency 2340 Percentage 18.00 %

Specialty Cardiology Frequency 1560 Percentage 12.00 %

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

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Professional Liability Insurance Information (PLI)

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

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36217

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36227 Tracking Number S7 Original Specialty Recommended RVU: **3.18**
Presented Recommended RVU: **2.32**
Global Period: ZZZ RUC Recommended RVU: **2.32**

CPT Descriptor: Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male has sudden onset of severe headache with a brief period of unconsciousness. A non-contrast CT scan demonstrates diffuse subarachnoid hemorrhage. Angiography of the intracranial circulation fails to demonstrate etiology of hemorrhage. A diagnostic external carotid arteriogram is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 86%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work:

Description of Intra-Service Work:
• A steerable guidewire is inserted and the catheter is advanced into the external carotid artery over the guidewire under fluoroscopic guidance.
• Multiple contrast material injections are made and digital imaging of the extracranial carotid distribution is acquired in AP, oblique, and lateral projections.
• The selective catheter is removed
• A formal report including image interpretation of the external carotid is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Babak Jahromi, MD, Clifford Kavinsky, MD and Richard Wright, MD		
Specialty(s):	SIR, ACR, ASNR, AANS/CNS, ACC/SCAI, AAN		
CPT Code:	36227		
Sample Size:	4037	**Resp N:** 35	**Response:** 0.8 %
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected ACC/SCAI - 103 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	13.00	**40.00**	100.00	300.00
Survey RVW:	1.20	3.00	**3.18**	5.00	8.10
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	10.00	**15.00**	30.00	90.00

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

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

Specialty Society Recommended Data

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

CPT Code:	36227	**Recommended Physician Work RVU: 2.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**

Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61641	ZZZ	4.33	**RUC Time**

CPT Descriptor Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13133	ZZZ	2.19	**RUC Time**	11,022

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	121,058

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

Other Reference CPT Code	Global	Work RVU	Time Source
37250	ZZZ	2.10	**RUC Time**

CPT Descriptor Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 17.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 36227**	**Key Reference CPT Code:** 61641	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	30.00	

Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	4.00
Urgency of medical decision making	4.00	4.17
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.17	3.83
Physical effort required	3.33	3.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	2.67
Outcome depends on the skill and judgment of physician	3.67	3.00
Estimated risk of malpractice suit with poor outcome	3.33	2.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.50	3.33
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Preamble

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup.

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address complex clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Background
Code 362X36227 (*Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) (Use 362X36227 in conjunction with 362362236222, 362X36223, or 362X36224))* is an add-on code to report unilateral selective arterial catheter placement and diagnostic imaging of the ipsilateral external carotid circulation.

Recommendation
The societies are recommending 2.32 RVUs with an intra-time of 15 minutes. This is considerably less than the median or 25th percentile survey responses. 36227 is currently reported using 36218 (1.01 RVUs; *Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate))* and 75660 (1.31 RVUs; *Angiography, external carotid, unilateral, selective, radiological supervision and interpretation*) for a total RVU of 2.32. Our recommended RVU is based on a crosswalk from this previous value as well as comparison with the key reference service as well as additional codes in the RUC database. Our expert panel compared the survey responses as well as the key reference service selected. The survey median time of 15 minutes is half of the intra-service time of the key reference code. It was judged that although the difficulty of catheterizing multiple tortuous branches of the external carotid artery would be similar in intensity to the work of the key reference service (61641), we could not support that 36227 was significantly more intense than 61641.

Selective catheterization and angiography of the external carotid artery, as currently coded, allows for reporting of the code pair for each additional vessel catheterized within the vascular family. 36227 can only be coded once per operative session despite the fact that the typical patient will require catheterization of multiple external carotid branches. These result in a significant reduction in reimbursement for the typical procedure performed on the typical patient. Similarly, all base codes in the overall family of cerebral codes are either being recommended for a large reduction in reimbursement (36236222-36236226) or no change in reimbursement (36236221). The revision of the family of cerebral codes is expected to result in a net savings to CMS.

Our expert panel believes that the technique, patient population and specialties performing the procedure have changed. Noninvasive imaging techniques have become the preferred method of evaluating the vascular anatomy of patients demonstrated by the significant decrease in the volume of angiographic procedures being performed. The patients who ultimately undergo catheter angiography are as a result more complex with more difficult problems. Physicians who normally perform this procedure encounter wide variability among the various branches of the external carotid artery (which supply blood to the face, pharynx, thyroid, tongue, etc.), increasing the complexity relative to catheterization and imaging in the common carotid artery. Because of their size, tortuosity and rapid arborization, there is a higher risk of catheter-induced vasospasm, intimal flap and vessel dissection than for the common or internal carotid arteries, resulting in the work requiring a greater level of skill and having a high level of intensity.

The external carotid artery, in addition to supplying critical, often unforgiving territory like the tongue, dura and cranial nerves, has dangerous anastamoses between its branches and the blood vessels of the brain. These dangerous anastamoses require sophistication to recognize, thereby increasing the intensity of the work provided. The expert panel felt that the 15 minutes intra-time reported by the survey respondents underestimated the time and work involved in the typical patient. The typical patient and procedure will require super-selective catherterization of multiple external carotid branches under the current coding paradigm. This additional work would be captured by multiple instances of coding the current code pair. We feel it is likely that the survey respondents did not take into account the fact that 36227 can only be coded once per side.

Post Times

The consensus panel recommends 10 minutes of post time for 36227 and 10 minutes of post time for 36228. The majority of the surveying societies used the "ZZZ (with pre/post time if necessary)" survey instrument, which collected pre/post times from the survey respondents. ASNR and ACR used the standard ZZZ survey tool that did not collect pre/post data.

The median post service time for the survey respondents that used the ZZZ (with pre/post) was 10 minutes for 36227 and 20 minutes for 36228. It is important to note that these surveys were from what is expected to be the dominant provider.

In the post service period the imaging sequences are reviewed frame by frame through the arterial, capillary and venous phases of the angiographic run. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts.

Key Reference Service

Our recommendation is bracketed by the two most commonly chosen Key Reference Services, each chosen by 6 respondents: 61641 (4.33 RVUs; 30 min. intra-service time; *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure))* and 37250 (2.10 RVUs; 23 min. intra-service time; *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)).* The external carotid artery has complex anatomy with dangerous anastamoses; it supplies crucial structures of the face and neck. Procedures within this anatomy inherently have great intensity. Even though the time for 37250 is higher (23 minutes), our panel felt that working in the complexity of the external carotid circulation justified a greater intensity for 36236227 relative to 37250. With its multiple branches, critical structural supply and dangerous anastomoses, the external carotid circulation is more complex and has great intensity.

MPC Codes

Our recommendation is also bracketed by two ZZZ MPC codes 13133 (2.19 RVUs; 30 min. intra-service time; *Repair, complex, forehead, cheeks, chin , mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure))* and 63048 (3.47 RVUs, 45 min. intra-service time, *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)).* The external carotid artery has complex anatomy with dangerous anastamoses; it supplies crucial structures of the face and neck. Procedures within this anatomy inherently have great intensity. Even though the time for 13133 is higher (30 minutes), our panel felt that working in the complexity of the external carotid circulation justified a greater intensity for 36236227 relative to 13133.

Comparison to other ZZZ codes

Our recommendation also compares favorably to other ZZZ codes including 61782 (3.18 RVUs, 25 minutes intra-service time (40 min total time); *Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure))* a code which also involves the brain.

In summary, our expert panel is recommending 2.32 RVUs, 15 minutes of intra-time and a post time of 10 minutes based on the comparisons detailed above.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to the attached budget neutrality table for information on previous reporting.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology How often? Commonly

Specialty NeuroSurgery How often? Commonly

Specialty Cardiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 18,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to the attached budget neutrality table for estimated reporting.

Specialty Radiology Frequency 9900 Percentage 55.00 %

Specialty NeuroSurgery Frequency 3420 Percentage 19.00 %

Specialty Cardiology Frequency 1980 Percentage 11.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36218

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36228 Tracking Number S8 Original Specialty Recommended RVU: **5.50**
Presented Recommended RVU: **4.25**
Global Period: ZZZ RUC Recommended RVU: **4.25**

CPT Descriptor: Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents with sudden onset of severe headache with a brief period of unconsciousness. A CT scan demonstrates a right frontal hemorrhage and findings suspicious for a 4 cm arteriovenous malformation. A diagnostic cerebral arteriogram is requested. Initial angiography confirms an anterior circulation arteriovenous malformation supplied by the right middle cerebral artery. Selective angiography of right middle cerebral artery is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 74%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work:

Description of Intra-Service Work:
• Under fluoroscopic guidance an exchange length guidewire is navigated into the distal internal carotid artery and the selective catheter is exchanged for a guide catheter. The guide catheter is attached to a Touhy-Borst adapter and a heparinized flush.
• A baseline activated clotting time is obtained. Heparin based on the patient's weight is administered intra-venously and a repeat activated clotting time is obtained to insure that adequate anti-coagulation has been established. If necessary additional heparin is administered and subsequent activated clotting times are obtained.
• A microcatheter over a microguidewire is inserted into the guide catheter and is navigated into a distal branch of the middle cerebral artery under roadmap fluoroscopic guidance. Multiple roadmaps may be required. The microwire is removed and the microcatheter is flushed with normal saline.
• Contrast material is injected and digital imaging of the distal middle cerebral artery territory in at least two projections into the arterial, capillary, and venous phases is performed. If necessary, additional oblique views are obtained to delineate the pathology

• Contrast material is injected manually or with a power injector into the guide catheter and digital imaging of the intracranial carotid distribution is acquired in AP and lateral projections into the arterial, capillary, and venous phases in order to rule out thromboembolic complications, contrast extravasation, or vascular injury.
• A post-procedure activated clotting time is obtained
• A formal report including image interpretation of the right middle cerebral artery is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Sean Tutton, MD, Michael Hall, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Timothy Swan, MD, William Julien, MD, Geraldine McGinty, MD, Zeke Silva, MD, Joshua A Hirsch, MD, Gregory N Nicola, MD, John Ratliff, MD, John Wilson, MD, Alexander Mason, MD, Babak Jahromi, MD, Clifford Kavinsky, MD and Richard Wright, MD		
Specialty(s):	SIR, ACR, ASNR, AANS/CNS, ACC/SCAI, AAN		
CPT Code:	36228		
Sample Size:	4037	**Resp N:** 35	**Response:** 0.8 %
Description of Sample:	SIR - 100 Neuro Section ACR - 1500 Randomly selected ASNR - 1,998 Randomly selected ACC/SCAI - 103 Targeted sample/CARE Registry AANS/CNS - 300 Cerebrovascular Section AAN - 36 Targeted sample		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**25.00**	75.00	200.00
Survey RVW:	2.00	4.25	**5.50**	8.00	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	25.00	**30.00**	50.00	180.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	36228	**Recommended Physician Work RVU: 4.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**

Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61642	ZZZ	8.66	**RUC Time**

CPT Descriptor Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35600	ZZZ	4.94	**RUC Time**	1,998

CPT Descriptor 1 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63295	ZZZ	5.25	**RUC Time**	40

CPT Descriptor 2 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
33924	ZZZ	5.49	**RUC Time**

CPT Descriptor Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 25.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 36228**	**Key Reference CPT Code:** 61642	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	0.00	0.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.56	4.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.78	4.56
Urgency of medical decision making	4.22	4.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	4.67
Physical effort required	4.11	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.67	4.56
Outcome depends on the skill and judgment of physician	4.56	4.33
Estimated risk of malpractice suit with poor outcome	4.67	4.56

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.78	4.78
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Preamble

Advances in cross sectional imaging (e.g., CTA and MRA) of the cervicocerebral arteries have revolutionized vascular radiology. Previously, invasive catheter-based diagnostic angiography was routinely utilized in the evaluation of vascular malformations, cerebrovascular occlusive pathology, tumor anatomy, and aneurismal disease. Non-invasive imaging has been widely accepted as first line in evaluation of such patients. This technological advance has resulted in a change of the patient population who requires catheter-based cerebral imaging. Catheter angiography of the cervicocerebral vasculature is now typically used to address specific clinical questions that persist following non-invasive imaging.

There have also been significant technical advances in the equipment required to perform catheter-based cerebral angiography. The actual catheters, guidewires, and coaxial systems now allow for superselective intracranial vessel catheterization that was not imaginable in the early 1990's when these CPT codes were valued. Although technical advances have been vast, the intensity has not lessened and remains plagued by a significant risk of thromboembolic stroke, vasospasm, and dissection.

These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology. The expert panel has discussed these code sets and believes that there is a rank order present with respect to clinical work, stroke risk/vessel injury, and involved imaging. We are presenting recommendations based on this magnitude estimation with some recommendations at maintenance of current value, some recommendations at median survey value, and some recommendations below the median surveyed value.

The bundled codes now describe both the selective arterial catheterization and the diagnostic angiography required to accurately image specific areas of the cervicocerebral vascular tree. This includes gaining vascular access, placement of an intra-arterial sheath, and retrograde navigation of a guidewire and catheter from puncture site to the artery in question. It also includes application of pressure or placement of a closure device upon completion.

- 36221 describes the placement of an arterial catheter non-selectively in the ascending aorta along with imaging of the cervicocerebral arch. 36221 may be reported by itself when no other selective cerebral imaging is necessary for diagnosis. If a more selective catheterization is required, the work included in 36221 becomes part of the more selective code and 36221 is not separately reported.

- 36222, 36223, and 36224 describe ipsilateral selective arterial catheterization with extracranial and/or intracranial carotid angiography with incremental time and intensity as listed in the code description.

- 36222 bundles the work of second order right common carotid artery selective catheterization (36216) with cervical carotid angiography (75676) as well as arch aortography (75650), if performed.

- 36223 includes all of the work of 36222 plus the addition of unilateral cerebral carotid angiography (75665), performed from the catheter in the common carotid artery.

- 36224 encompasses all the work of 36223 as well as further selection of the internal carotid artery bringing it to a third order vessel (36217) and follow-up intracranial imaging in multiple projections (75774), performed from the catheter in the internal carotid artery.

- Add-on code 36228 describes further microcatheter selection of the intracranial ICA branches such as the ACA or MCA. These selections were previously reported with codes 36217 or 36218 for catheterization and code 75774 for the angiography of each arterial bed.

- Add-on code 36227 describes external carotid artery selection for imaging which may be appropriate in specific clinical scenarios. All further manipulation in the ECA is bundled as is all further follow-up selective ECA angiography. Previously, this included 36218 for the additional catheter selection and 75660 for the additional selective imaging.

- 36225 and 36226 describes a bundled assessment of the posterior circulation, whether the actual vertebral artery is selected or if the catheter is placed in a lower order vessel in the vascular family. The codes include ipsilateral selective arterial catheterization with extracranial and/or intracranial vertebral angiography with increasing time and intensity as listed in the code description. Vertebral imaging from a non-selective catheterization of the aorta would be reported with 36221.

- 36225 describes the second order selective catheterization of the right subclavian artery (36216) and both intracranial and extracranial vertebral artery angiography (75685) as well as arch aortography (75650), if performed.

- 36226 encompasses all the work of 36225 as well as further selection of the vertebral artery itself bringing it to a third order vessel (36217) and follow-up imaging in multiple projections (75774).

Bilateral procedures would require the -50 modifier if the same vessel selection and imaging were performed.

Background
Code 362X36228 (*Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure). (Use 362X36228 in conjunction with 362X36224 or 362X36226))* is an add-on code to report unilateral selective arterial catheter placement and diagnostic imaging of the initial and each additional intracranial branch of the internal carotid or vertebral arteries.

Recommendation
The societies are recommending 4.25 RVUs (the 25th percentile) and an intra-time of 30 minutes. The revised code structure does not have direct equivalents in the current code structure that are parallel or able to be directly cross-walked, having different base code values and different descriptions of work, so our recommendation does not necessarily represent an increase in value for this procedure. An intracranial selective catherterization(s) and imaging would be currently reported using a combination of three codes 36217 (6.29 RVUs; *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family*) or 36218 (1.01 RVUs; *Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate))* and 75774 (0.36 RVUs and *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)).* 36218 would be reported for each additional vessel catheterized within a vascular family. 36228 can only be reported a maximum of twice per hemisphere regardless of the number of vessels supra-selectively catheterized. This will result in a significant reduction in reimbursement for the typical procedure performed on the typical patient. Similarly, all base codes in the overall family of cerebral codes are either being recommended for a large reduction in reimbursement (36236222-36236226) or no change in reimbursement (36236221). The revision of the family of cervicocarotid codes should result in a net savings to CMS.

Our expert panel believes and our survey results confirm that the additional work required for super-selective angiography of the ACA, MCA, PCA, etc. is a big step up from work that is in first and second order carotid arteries. The utilization of a microcatheter and microwire through a guide catheter requires more time and technical expertise than the equipment and technique used for first and second order vessels. Almost every injection for this procedure is a hand-run injection through a microcatheter of 1-3 CCs, as opposed to automated power injection. Working in the smaller intracranial blood vessels, which have little elasticity and muscularity, has a much higher level of intensity and stress, and requires a higher level of skill.

Post Times
The consensus panel recommends 10 minutes of post time for 36227 and 10 minutes of post time for 36228. The majority of the surveying societies used the "ZZZ (with pre/post time if necessary)" survey instrument, which collected pre/post times from the survey respondents. ASNR and ACR used the standard ZZZ survey tool that did not collect pre/post data.

The median post service time for the survey respondents that used the ZZZ (with pre/post) was 10 minutes for 36227 and 20 minutes for 36228. It is important to note that these surveys were from what is expected to be the dominant provider. The consensus panel agreed that there is additional immediate post procedure time required for the interpretation of the highly detailed and numerous angiographic images obtained of the distal cerebral vasculature. The interpretation of these images require a high level of skill and significant time above and beyond what is accounted for by the additional time in the base codes. In the post service period, the imaging sequences are reviewed frame by frame through the arterial, capillary and venous phases of the angiographic run. The various projections are compared to each other to detect pathology as opposed to normal anatomy as overlapping and tortuous vessels are typical. Subtracted and unsubtracted images are compared to assess for motion and other artifacts. However, the expert panel did not feel that the immediate post service time would be greater for 36228 than for 36227 and therefore have recommended reducing the survey immediate post service time to 10 minutes from the 20 minutes suggested by the survey.

Key Reference Service

Our recommendation compares favorably to the most commonly chosen Key Reference Service: 61642 (8.66 RVUs, 60 minutes intra-service time; *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)).* Even though the time for 61642 is higher (60 minutes), both codes involve working in the super-selective intracerebral vascular bed. The mean intensity/complexity survey responses for 36236228 were greater than or equal to the mean responses for 61642 for all but one of the eleven intensity/complexity survey questions. Catheterization with a microcatheter and microwire of the middle, anterior and posterior cerebral arteries, is intense, as challenges in this circulation are devastating, including stroke, intracranial hemorrhage and death. Interpretation of these microcatheter arteriograms is time intensive and requires great skill.

MPC Codes

Our recommendation also compares favorably to MPC code 35600 (4.94 RVUs, 40 minutes intra service time; *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)*). 36228 intra service time is 10 minutes less but contains additional 10 minutes of immediate post service time that is not present in 35600. Furthermore, 36228 is recommended at 0.69 RVUs less than 35600. 35600 is an open procedure on a peripheral artery requiring significant technical skill and care to preserve the integrity of this vascular graft which will be used as a conduit for coronary artery bypass procedure. Our panel felt that working in the complex super-selective cerebral circulation justifies the greater intensity of 36228. Catheterization with a microcatheter and microwire of the middle, anterior and posterior cerebral arteries, is intense, as challenges in this circulation are devastating, including stroke, intracranial hemorrhage and death. Interpretation of these microcatheter arteriograms is time intensive and requires great skill.

Additionally, MPC code 63295 (5.25 RVUs; 45 minutes intra-service time; *Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure))* further supports the value recommended. Our panel felt that as noted above, working in the complex super-selective cerebral circulation justifies the greater intensity demonstrated by the fact that 63295 has only one additional RVU despite 15 minutes additional intra service time (although 36228 has 10 minutes immediate post procedure time which is not present in 63295).

Comparison to other ZZZ codes

Our recommendation also compares favorably to ZZZ code 33924 (5.49 RVUs; 30 minutes intra-service time; *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure))* a code which also involves work in a complex vascular bed. Another comparison code is ZZZ code 33572 (4.44 RVUs, 30 minutes intrs-service time; *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)*).

In summary, our expert panel is recommending 4.25 RVUs (the 25th percentile), intra service period of 30 minutes and 10 minutes of post service based on the comparisons detailed above.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. While other services might be reported on the same date of service, there is no 'typical' scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Please refer to the attached budget neutrality table for information on previous reporting.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology How often? Commonly

Specialty NeuroSurgery How often? Commonly

Specialty Cardiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to the attached budget neutrality table for estimated reporting.

Specialty Radiology Frequency 8250 Percentage 55.00 %

Specialty NeuroSurgery Frequency 2850 Percentage 19.00 %

Specialty Cardiology Frequency 1650 Percentage 11.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36218

SS Rec Summary

ISSUE: Cervicocerebral Angiography

TAB: 14

Source	CPT	DESC	Glob	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	**36251**	Selective catheter placement (first-order)	**000**	**20**	**0.085**			**5.35**			**116**	**33**	**3**	**5**			**45**			**30**
RUC(2011)	36200	Introduction of catheter, aorta	000		0.058			3.02			91	33	3	5			30			20
CMS/oth	75650	Angiography, cervicocerebral, catheter, ir	XXX		N/A			1.49			28									
CURRENT		**36200+75650**						**4.51**			**119**									
SVY	**36221**	Non-selective catheter placement, thorac	**000**	**55**	**0.101**	**2.00**	**4.66**	**5.00**	**5.90**	**8.10**	**125**	**45**	**10**	**10**	**15**	**20**	**30**	**48**	**90**	**30**
REC					**0.087**			**4.51**			**118**	**40**	**3**	**5**			**30**			**40**
REF	**36251**	Selective catheter placement (first-order)	**000**	**19**	**0.085**			**5.35**			**116**	**33**	**3**	**5**			**45**			**30**
Hvd	36216	Selective catheter placement, arterial sys	XXX		0.073			5.27			72						72			
CMS/oth	75650	Angiography, cervicocerebral, catheter, ir	XXX		N/A			1.49			28									
CMS/oth	75676	Angiography, carotid, cervical, unilateral,	XXX		N/A			1.31			25									
CURRENT		**36216+75650+75676**						**8.07**			**125**									
SVY	**36222**	Selective catheter placement, common c	**000**	**55**	**0.100**	**3.00**	**5.53**	**6.00**	**8.00**	**10.00**	**135**	**45**	**10**	**10**	**10**	**30**	**40**	**60**	**120**	**30**
REC					**0.103**			**6.00**			**128**	**40**	**3**	**5**			**40**			**40**
REF	**36253**	Superselective catheter placement (one c	**000**	**18**	**0.101**			**7.55**			**131**	**33**	**3**	**5**			**60**			**30**
Hvd	36216	Selective catheter placement, arterial sys	XXX		0.073			5.27			72						72			
CMS/oth	75650	Angiography, cervicocerebral, catheter, ir	XXX		N/A			1.49			28									
CMS/oth	75665	Angiography, carotid, cerebral, unilateral,	XXX		N/A			1.31			25									
CMS/oth	75676	Angiography, carotid, cervical, unilateral,	XXX		N/A			1.31			25									
CURRENT		**36216+75650+75665+75676**						**9.38**			**150**									
SVY	**36223**	Selective catheter placement, common c	**000**	**55**	**0.109**	**4.00**	**6.00**	**7.00**	**8.05**	**10.50**	**145**	**45**	**15**	**10**	**20**	**30**	**45**	**60**	**120**	**30**
REC					**0.102**			**6.50**			**133**	**40**	**3**	**5**			**45**			**40**
REF	**36253**	Superselective catheter placement (one c	**000**	**18**	**0.101**			**7.55**			**131**	**33**	**3**	**5**			**60**			**30**
Hvd	36217	Selective catheter placement, arterial sys	XXX		0.073			6.29			86						86			
CMS/oth	75650	Angiography, cervicocerebral, catheter, ir	XXX		N/A			1.49			28									
CMS/oth	75665	Angiography, carotid, cerebral, unilateral,	XXX		N/A			1.31			25									
CMS/oth	75676	Angiography, carotid, cervical, unilateral,	XXX		N/A			1.31			25									
CURRENT		**36217+75650+75665+75676**						**10.40**			**164**									
SVY	**36224**	Selective catheter placement, internal car	**000**	**43**	**0.113**	**4.00**	**6.50**	**8.00**	**9.00**	**11.50**	**165**	**55**	**15**	**15**	**20**	**36**	**50**	**60**	**135**	**30**
REC					**0.113**			**7.55**			**138**	**40**	**3**	**5**			**50**			**40**
REF	**36251**	Selective catheter placement (first-order)	**000**	**18**	**0.085**			**5.35**			**116**	**33**	**3**	**5**			**45**			**30**
Hvd	36215	Selective catheter placement, arterial sys	XXX		0.077			4.67			61						61			
CMS/oth	75650	Angiography, cervicocerebral, catheter, ir	XXX		N/A			1.49			28									
CMS/oth	75685	Angiography, vertebral, cervical, and/or ir	XXX		N/A			1.31			25									
CURRENT		**36215+75650+75685**						**7.47**			**114**									
SVY	**36225**	Selective catheter placement, subclavian	**000**	**55**	**0.098**	**3.00**	**5.60**	**6.50**	**8.05**	**12.00**	**145**	**50**	**10**	**10**	**18**	**30**	**45**	**60**	**105**	**30**
REC					**0.102**			**6.50**			**133**	**40**	**3**	**5**			**45**			**40**

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	P	Q	R	S	T	U	V	W
5							RVW					Total	PRE-TIME			INTRA-TIME					IMMD
6	Source	CPT	DESC	Glob	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
52																					
53	REF	36253	Superselective catheter placement (one	000	18	0.101			7.55			131	33	3	5			60			30
54	Hvd	36217	Selective catheter placement, arterial sys	XXX		0.073			6.29			86						86			
55	CMS/oth	75650	Angiography, cervicocerebral, catheter, ir	XXX		N/A			1.49			28									
56	CMS/oth	75685	Angiography, vertebral, cervical, and/or ir	XXX		N/A			1.31			25									
57	CURRENT		36217+75650+75685						9.09			139									
58	SVY	36226	Selective catheter placement, vertebral a	000	43	0.115	5.50	7.25	8.00	9.00	11.50	160	50	15	15	20	35	50	60	120	30
59	REC					0.113			7.55			138	40	3	5			50			40
60																					
61																					
62	REF	61641	Balloon dilatation of intracranial vasospas	ZZZ	6	0.144			4.33			30	0					30			0
63	REF	37250	Intravascular ultrasound (non-coronary v	ZZZ	6	0.091			2.10			23	0					23			0
64	Hvd	36218	Selective catheter placement, arterial sys	ZZZ		0.072			1.01			14						14			
65	CMS/oth	75660	Angiography, external carotid, unilateral,	XXX		N/A			1.31			25									
66	CURRENT		36218+75660						2.32			39									
67	SVY	36227	Selective catheter placement, external ca	ZZZ	35	0.212	1.20	3.00	3.18	5.00	8.10	15	0			10	10	15	30	90	0
68	REC					0.197			3.18			25	0					15			10
69																					
70																					
71	REF	61642	Balloon dilatation of intracranial vasospas	ZZZ	9	0.144			8.66			60	0					60			0
72	Hvd	36218	Selective catheter placement, arterial sys	ZZZ		0.072			1.01			14						14			
73	CMS/oth	75774	Angiography, selective, each additional v	ZZZ		N/A			0.36			9									
74	CURRENT		32618+75774						1.37			23									
75	SVY	36228	Selective catheter placement, each intrac	ZZZ	35	0.183	2.00	4.25	5.50	8.00	10.00	30	0			15	25	30	50	180	0
76	REC					0.168			5.50			50	0					30			20
77																					

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

Meeting Date: 04/2012

Global Period: 000

36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Global Period: ZZZ

+36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

+**36228** Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure).

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A multispecialty group (SIR, ACR, SVS, ACC/SCAI, ASNR, AANS/CNS) convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these newly created CPT codes.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

We selected CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* as our reference code. CPT code 36251 was reviewed by the RUC/PEAC in April 2011. The process of care is similar for the newly created codes to the reference code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Phone calls & prescriptions
- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD
-

Service Clinical Labor Activities:

The patient is greeted, gowning is provided and patient is escorted to procedure room. The nurse obtains vital signs, interviews the patient for allergies, medications and coagulopathy. Procedure is explained and informed consent is witnessed. The rad tech prepares the room, equipment and supplies after consulting with the M.D regarding the supplies to be used. The angio tech prepares the back table. IV access is established. The patient is positioned, including securing the patient's head into the appropriate position. The patient's skin is prepped and the patient is draped, all in routine sterile fashion. The rad tech also verifies that patient and equipment are properly positioned for bi-plane imaging. RN administers conscious sedation. The angio tech assists the M.D. performing procedure. The rad tech assists the MD with flouro, contrast, image acquisition, etc. The patient is escorted to the observation area. RN performs sequential vital signs over 4 hour observation. Rad Tech processes the bi-plane images and completes all the necessary paperwork. The angio tech cleans the room. The patient is given discharge instructions.

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

Meeting Date: 04/2012

Global Period: 000

36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Global Period: ZZZ

+36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

+**36228** Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure).

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We selected CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* as our reference code. CPT code 36251 was reviewed by the RUC/PEAC in April 2011. The process of care is similar for the newly created codes to the reference code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Schedule space and equipment in facility

Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	**REVISED**			**36251**		**36221**		**36222**		**36223**		**36224**		**36225**		**36226**		**36227**		**36228**	
2	**Meeting Date: April 2012** **Specialty: SIR, ACR, ASNR, SVS, ANNS/CNS, ACC**	**CMS**	**Staff**	***Renal Approved April 2011*** ***Selective catheter placement (first-order); unilateral*** ***APPROVED April 2011***		***Non Selective catheter, thoracic/arch aortography***		***Selective catheter, CC or innominate; EC angio, unilateral*** ***36216+75650+75676***		***Selective catheter, CC or innominate; IC angio, unilateral*** ***36216+75650+75665+7567***		***Selective catheter, ICA; IC angio, unilateral*** ***36217+75650+75665+756***		***Selective catheter, subc or innominate; vert angio; unilateral*** ***36215+75650+75685***		***Selective catheter, vertebral art; vert angio, unilateral*** ***36217+75650+75685***		***Selective catheter, ECA; EC angio, unilateral*** ***36218+75660***		***Selective catheter, intracranial branch of carotid or vertebral; angio, unilateral*** ***36218+75774***	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
5	***UNDER CURRENT COMPONENT CODING SCENARIO***					***217***		***291***		***397***		***411***		***280***		***305***		***106***		***50***	
6	**TOTAL CLINICAL LABOR TIME**			**253**	**9**	**177**	**9**	**232**	**9**	**246**	**9**	**260**	**9**	**246**	**9**	**260**	**9**	**47**	**0**	**92**	**0**
7	*RN*	*L051A*	*RN*	*107*		*92*		*102*		*107*		*112*		*107*		*112*		*15*		*30*	
8	*RN/LPN/MTA*	*L037D*	*RN/LPN/MTA*	*41*	*9*	*27*	*9*	*27*	*9*	*27*	*9*	*27*	*9*	*27*	*9*	*27*	*9*	*4*	*0*	*8*	*0*
9	*Angio Tech*	*L041A*	*AngioTech*	*59*		*39*		*59*		*64*		*69*		*64*		*69*		*17*		*32*	
10	*Rad Tech*	*L041B*	*Rad Tech*	*46*		*19*		*44*		*48*		*52*		*48*		*52*		*11*		*22*	
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**0**	**0**	**0**	**0**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**235**	**0**	**159**	**0**	**214**	**0**	**228**	**0**	**242**	**0**	**228**	**0**	**242**	**0**	**47**	**0**	**92**	**0**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**0**	**0**	**0**	**0**
14	**PRE-SERVICE**																				
15	**Start: Following visit when decision for surgery or procedure made**																				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3				
17	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3		3		3				
19	Provide pre-service education/obtain consent																				
20	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
21	Other Clinical Activity (please specify): Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	AngioTech	6		6		6		6		6		6		6					
22	**End: When patient enters office/facility for surgery/procedure**																				
23	**SERVICE PERIOD**																				
24	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**																				
25	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		3		3		5		3		3		3					
26	Obtain vital signs	L037D	RN/LPN/MTA	5		3		3		5		3		3		3					
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5		5		5		5					
28	Prepare room, equipment, supplies (including imaging equipment)	L041B	Rad Tech	7		7		7		7		7		7		7				0	
29	Setup scope (non facility setting only)																				
30	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		7		7		7		7		7		7					
31	Sedate/apply anesthesia	L051A	RN	2		2		2		2		2		2		2					
32	**Intra-service**																				
33	Assist physician in performing procedure	L041A	AngioTech	45		30		40		45		50		45		50		15		30	
34	Assist physician in performing procedure (CS)	L051A	RN	45		30		40		45		50		45		50		15		30	
35	Assisting with flouroscopy/image acquisition (75%)	L041B	Rad Tech	34		23		30		34		38		34		38		11		22	
36	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA	11		8		10		11		13		11		13		4		8	
37	Image Post Processing	L041A	AngioTech	5		0		10		10		10		10		10		2		2	
38	**Post-Service**																				
39	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60		60		60		60		60		60					
40	Clean room/equipment by physician staff	L041A	AngioTech	3		3		3		3		3		3		3					
41	Clean Scope																				
42	Clean Surgical Instrument Package																				
43	Complete diagnostic forms, lab & X-ray requisitions																				
44	Review/read X-ray, lab, and pathology reports																				
45	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
46	Discharge day management																				
47	Other Clinical Activity (please specify)																				
48	**End: Patient leaves office**																				
49	**POST-SERVICE Period**																				
50	**Start: Patient leaves office/facility**																				
51	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3				
52	*Office visits: None*																				
60	*Total Office Visit Time*			0	0	0	0	0	0	0	0	0	0	0	0	0	0				
61	Other Activity (please specify)																				
62	**End: with last office visit before end of global period**				0		0		0		0		0		0		0				

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	**REVISED**			**36251**		**36221**		**36222**		**36223**		**36224**		**36225**		**36226**		**36227**		**36228**	
2	**Meeting Date: April 2012** **Specialty: SIR, ACR, ASNR, SVS, ANNS/CNS, ACC**	**CMS**	**Staff**	***Renal Approved April 2011*** ***Selective catheter placement (first-order); unilateral*** ***APPROVED April 2011***		***Non Selective catheter, thoracic/arch aortography***		***Selective catheter, CC or innominate; EC angio, unilateral*** ***36216+75650+75676***		***Selective catheter, CC or innominate; IC angio, unilateral*** ***36216+75650+75665+7567***		***Selective catheter, ICA; IC angio, unilateral*** ***36217+75650+75665+756***		***Selective catheter, subc or innominate; vert angio; unilateral*** ***36215+75650+75685***		***Selective catheter, vertebral art; vert angio, unilateral*** ***36217+75650+75685***		***Selective catheter, ECA; EC angio, unilateral*** ***36218+75660***		***Selective catheter, intracranial branch of carotid or vertebral; angio, unilateral*** ***36218+75774***	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
63	**MEDICAL SUPPLIES**		**Unit**																		
64	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1					
65	pack, conscious sedation	SA044	pack	1		1		1		1		1		1		1					
66	gown, surgical, sterile	SB028	item	2		2		2		2		2		2		2					
67	gloves, sterile	SB024	pair	2		2		2		2		2		2		2					
68	mask, surgical, with face shield	SB034	item	4		4		4		4		4		4		4					
69	cap, surgical	SB001	item	4		4		4		4		4		4		4					
70	shoe covers, surgical	SB039	pair	4		4		4		4		4		4		4					
71	tray, shave prep	SA067	tray	1		1		1		1		1		1		1					
72	underpad 2ftx3ft (Chux)	SB044	item	1		1		1		1		1		1		1					
73	drape, sterile, femoral	SB009	item	1		1		1		1		1		1		1					
74	drape-towel, sterile 18inx26in	SB019	item	4		4		4		4		4		4		4					
75	Betadine	SJ041	ml	60		60		60		60		60		60		60					
76	applicator, sponge-tipped	SG009	item	4		4		4		4		4		4		4					
77	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10		10		10		10		10		10					
78	syringe 10-12 ml	SC051	item	4		4		4		4		4		4		4					
79	syringe, 20 cc	SC053	item	4		4		4		4		4		4		4					
80	sodium chloride 0.9% flush syringe	SH065	item	2		2		2		2		2		2		2					
81	closed flush system, angiography	SC010	item	1		1		1		1		1		1		1					
82	syringe 5-6ml	SC057	item																	4	
83	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	SH096	item	1																	
84	heparin 1,000 units-ml inj	SH039	ml	5		5		5		5		5		5		5					
85	blade, surgical (Bard-Parker)	SF007	item	1		1		1		1		1		1		1					
86	steri-strip (6 strip uou)	SG074	item	1		1		1		1		1		1		1					
87	Sterile Radio-opaque ruler	SD249	item			1		1		1											
88	guidewire bowl w-lid, sterile	SD171	item	2		2		2		2		2		2		2					
89	gauze, sterile 4in x 4in	SG056	item	2		2		2		2		2		2		2					
90	dressing 3 X 4 wound care telfa	SG035	item	2		2		2		2		2		2		2					
91	drape, sterile, c-arm, fluoro	SB008	item	1		1		1		1		1		1		1					
92	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1		1		1		1		1		1					
93	manifold (for angiography)	SD180	item			1		1		1		1		1		1					
94	tubing, pressure injection line (angiography)	SD211	item	1		1		1		1		1		1		1					
95	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1		1		1		1		1					
96	vascular sheath	SD136	item	1		1		1		1		1		1		1					
97	guidewire, (Bentson)	SD172	item	1		1		1		1		1		1		1					
98	guidewire, hydrophilic (Glidewire)	SD089	item	1		1		1		1		1		1		1					
99	catheter, angiographic, pig-tail	SC008	item	1		1		1		1		1		1		1					
100	catheter (SIM2F1)	SD148	item	1				1		1		1		1		1					
101	kit, guidewire introducer (Micro-Stick)	SA016	kit	1		1		1		1		1		1		1					
102	catheter microcatheter selective	SD154	item																	1	
103	guidewire, steerable (Transcend)	SD175	item																	1	
104	catheter (Glide)	SD147	item					1		1		1		1		1					
105	suture device for vessel closure (Perclose A-T)	SD207	item	1		1		1		1		1		1		1					
106	x-ray ID card (flashcard)	SK093	item	1		1		1		1		1		1		1					
107	film, x-ray 14inx17in	SK034	item	2		2		4		4		4		4		4		4		4	
108	x-ray envelope	SK091	item	1		1		1		1		1		1		1					
109	x-ray developer solution	SK089	oz	6		6		6		6		6		6		6		6		6	
110	x-ray fixer solution	SK092	oz	6		6		6		6		6		6		6		6		6	
111																					
112	**Equipment**																				
113	room, angiography	EL011		62		49		59		64		69		64		69		15		30	
114	IV infusion pump	EQ032		287		272		282		287		292		287		292		15		30	
115	Contrast media warmer	EQ088		62		49		59		64		69		64		69		15		30	
116	film alternator	ER029		62		49		59		64		69		64		69		15		30	
117	ECG, 3-channel	EQ011		287		272		282		287		292		287		292		15		30	
118	Stretcher	EF018		287		272		282		287		292		287		292		15		30	
119	printer, dye sublimation	ED031		5		5		5		5		5		5		5		5		5	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	**REVISED**			**36251**		**36221**		**36222**		**36223**		**36224**		**36225**		**36226**		**36227**		**36228**	
2	**Meeting Date: April 2012** **Specialty: SIR, ACR, ASNR, SVS, ANNS/CNS, ACC**	**CMS**	**Staff**	***Renal Approved April 2011*** ***Selective catheter placement (first-order); unilateral*** ***APPROVED April 2011***		***Non Selective catheter, thoracic/arch aortography***		***Selective catheter, CC or innominate; EC angio, unilateral*** ***36216+75650+75676***		***Selective catheter, CC or innominate; IC angio, unilateral*** ***36216+75650+75665+7567***		***Selective catheter, ICA; IC angio, unilateral*** ***36217+75650+75665+756***		***Selective catheter, subc or innominate; vert angio; unilateral*** ***36215+75650+75685***		***Selective catheter, vertebral art; vert angio, unilateral*** ***36217+75650+75685***		***Selective catheter, ECA; EC angio, unilateral*** ***36218+75660***		***Selective catheter, intracranial branch of carotid or vertebral; angio, unilateral*** ***36218+75774***	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
5	***UNDER CURRENT COMPONENT CODING SCENARIO***					***217***		***291***		***397***		***411***		***280***		***305***		***106***		***50***	
6	**TOTAL CLINICAL LABOR TIME**			**253**	**9**	**210**	**9**	**245**	**9**	**260**	**9**	**275**	**9**	**260**	**9**	**275**	**9**	**47**	**0**	**93**	**0**
7	*RN*	*L051A*	*RN*	*107*		*92*		*102*		*107*		*112*		*107*		*112*		*15*		*30*	
8	*RN/LPN/MTA*	*L037D*	*RN/LPN/MTA*	*41*	*9*	*38*	*9*	*40*	*9*	*41*	*9*	*43*	*9*	*41*	*9*	*43*	*9*	*4*	*0*	*8*	*0*
9	*Angio Tech*	*L041A*	*AngioTech*	*59*		*44*		*59*		*64*		*69*		*64*		*69*		*17*		*32*	
10	*Angio Tech*	*L041B*	*Rad Tech*	*46*		*37*		*44*		*48*		*52*		*48*		*52*		*11*		*24*	
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**15**	**6**	**0**	**0**	**0**	**0**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**235**	**0**	**192**	**0**	**227**	**0**	**242**	**0**	**257**	**0**	**242**	**0**	**257**	**0**	**47**	**0**	**93**	**0**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**0**	**0**	**0**	**0**
14	**PRE-SERVICE**																				
15	**Start: Following visit when decision for surgery or procedure made**																				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3				
17	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3		3		3				
19	Provide pre-service education/obtain consent																				
20	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
21	Other Clinical Activity (please specify): Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	AngioTech	6		6		6		6		6		6		6					
22	**End: When patient enters office/facility for surgery/procedure**																				
23	**SERVICE PERIOD**																				
24	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**																				
25	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		5		5		5		5		5		5					
26	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5		5		5		5		5					
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5		5		5		5					
28	Prepare room, equipment, supplies (including imaging equipment)	L041B	Rad Tech	7		7		7		7		7		7		7				1	
29	Setup scope (non facility setting only)																				
30	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		7		7		7		7		7		7					
31	Sedate/apply anesthesia	L051A	RN	2		2		2		2		2		2		2					
32	**Intra-service**																				
33	Assist physician in performing procedure	L041A	AngioTech	45		30		40		45		50		45		50		15		30	
34	Assist physician in performing procedure (CS)	L051A	RN	45		30		40		45		50		45		50		15		30	
35	Assisting with flouroscopy/image acquisition (75%)	L041B	Rad Tech	34		23		30		34		38		34		38		11		23	
36	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA	11		8		10		11		13		11		13		4		8	
37	Image Post Processing	L041A	AngioTech	5		5		10		10		10		10		10		2		2	
38	**Post-Service**																				
39	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60		60		60		60		60		60					
40	Clean room/equipment by physician staff	L041A	AngioTech	3		3		3		3		3		3		3					
41	Clean Scope																				
42	Clean Surgical Instrument Package																				
43	Complete diagnostic forms, lab & X-ray requisitions																				
44	Review/read X-ray, lab, and pathology reports																				
45	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
46	Discharge day management																				
47	Other Clinical Activity (please specify)																				
48	**End: Patient leaves office**																				
49	**POST-SERVICE Period**																				
50	**Start: Patient leaves office/facility**																				
51	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3				
52	*Office visits: None*																				
60	*Total Office Visit Time*			0	0	0	0	0	0	0	0	0	0	0	0	0	0				
61	Other Activity (please specify)																				
62	**End: with last office visit before end of global period**				0		0		0		0		0		0		0				

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	**REVISED**			**36251**		**36221**		**36222**		**36223**		**36224**		**36225**		**36226**		**36227**		**36228**	
2	**Meeting Date: April 2012** **Specialty: SIR, ACR, ASNR, SVS, ANNS/CNS, ACC**	**CMS**	**Staff**	***Renal Approved April 2011*** ***Selective catheter placement (first-order); unilateral*** ***APPROVED April 2011***		***Non Selective catheter, thoracic/arch aortography***		***Selective catheter, CC or innominate; EC angio, unilateral*** ***36216+75650+75676***		***Selective catheter, CC or innominate; IC angio, unilateral*** ***36216+75650+75665+7567***		***Selective catheter, ICA; IC angio, unilateral*** ***36217+75650+75665+756***		***Selective catheter, subc or innominate; vert angio; unilateral*** ***36215+75650+75685***		***Selective catheter, vertebral art; vert angio, unilateral*** ***36217+75650+75685***		***Selective catheter, ECA; EC angio, unilateral*** ***36218+75660***		***Selective catheter, intracranial branch of carotid or vertebral; angio, unilateral*** ***36218+75774***	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
63	**MEDICAL SUPPLIES**		**Unit**																		
64	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1					
65	pack, conscious sedation	SA044	pack	1		1		1		1		1		1		1					
66	gown, surgical, sterile	SB028	item	2		2		2		2		2		2		2					
67	gloves, sterile	SB024	pair	2		2		2		2		2		2		2					
68	mask, surgical, with face shield	SB034	item	4		4		4		4		4		4		4					
69	cap, surgical	SB001	item	4		4		4		4		4		4		4					
70	shoe covers, surgical	SB039	pair	4		4		4		4		4		4		4					
71	tray, shave prep	SA067	tray	1		1		1		1		1		1		1					
72	underpad 2ftx3ft (Chux)	SB044	item	1		1		1		1		1		1		1					
73	drape, sterile, femoral	SB009	item	1		1		1		1		1		1		1					
74	drape-towel, sterile 18inx26in	SB019	item	4		4		4		4		4		4		4					
75	Betadine	SJ041	ml	60		60		60		60		60		60		60					
76	applicator, sponge-tipped	SG009	item	4		4		4		4		4		4		4					
77	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10		10		10		10		10		10					
78	syringe 10-12 ml	SC051	item	4		4		4		4		4		4		4					
79	syringe, 20 cc	SC053	item	4		4		4		4		4		4		4					
80	sodium chloride 0.9% flush syringe	SH065	item	2		2		2		2		2		2		2					
81	closed flush system, angiography	SC010	item	1		1		1		1		1		1		1					
82	syringe 5-6ml	SC057	item																	4	
83	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	SH096	item	1																	
84	heparin 1,000 units-ml inj	SH039	ml	5		5		5		5		5		5		5					
85	blade, surgical (Bard-Parker)	SF007	item	1		1		1		1		1		1		1					
86	steri-strip (6 strip uou)	SG074	item	1		1		1		1		1		1		1					
87	Sterile Radio-opaque ruler	SD249	item			1		1		1											
88	guidewire bowl w-lid, sterile	SD171	item	2		2		2		2		2		2		2					
89	gauze, sterile 4in x 4in	SG056	item	2		2		2		2		2		2		2					
90	dressing 3 X 4 wound care telfa	SG035	item	2		2		2		2		2		2		2					
91	drape, sterile, c-arm, fluoro	SB008	item	1		1		1		1		1		1		1					
92	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1		1		1		1		1		1					
93	manifold (for angiography)	SD180	item			1		1		1		1		1		1					
94	tubing, pressure injection line (angiography)	SD211	item	1		1		1		1		1		1		1					
95	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1		1		1		1		1					
96	vascular sheath	SD136	item	1		1		1		1		1		1		1					
97	guidewire, (Bentson)	SD172	item	1		1		1		1		1		1		1					
98	guidewire, hydrophilic (Glidewire)	SD089	item	1		1		1		1		1		1		1					
99	catheter, angiographic, pig-tail	SC008	item	1		1		1		1		1		1		1					
100	catheter (SIM2F1)	SD148	item	1				1		1		1		1		1					
101	kit, guidewire introducer (Micro-Stick)	SA016	kit	1		1		1		1		1		1		1					
102	catheter microcatheter selective	SD154	item																	1	
103	guidewire, steerable (Transcend)	SD175	item																	1	
104	catheter (Glide)	SD147	item					1		1		1		1		1					
105	suture device for vessel closure (Perclose A-T)	SD207	item	1		1		1		1		1		1		1					
106	x-ray ID card (flashcard)	SK093	item	1		1		1		1		1		1		1					
107	film, x-ray 14inx17in	SK034	item	2		2		4		4		4		4		4		4		4	
108	x-ray envelope	SK091	item	1		1		1		1		1		1		1					
109	x-ray developer solution	SK089	oz	6		6		6		6		6		6		6		6		6	
110	x-ray fixer solution	SK092	oz	6		6		6		6		6		6		6		6		6	
111																					
112	**Equipment**																				
113	room, angiography	EL011		62		49		59		64		69		64		69		15		31	
114	IV infusion pump	EQ032		287		272		282		287		292		287		292		15		31	
115	Contrast media warmer	EQ088		62		49		59		64		69		64		69		15		31	
116	film alternator	ER029		62		49		59		64		69		64		69		15		31	
117	ECG, 3-channel	EQ011		287		272		282		287		292		287		292		15		31	
118	Stretcher	EF018		287		272		282		287		292		287		292		15		31	
119	printer, dye sublimation	ED031		5		5		5		5		5		5		5		5		5	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Codes Reported Together- 75% or More Screen

January/April 2012

Bundle Thrombolysis

In 2010, the Relativity Assessment Workgroup identified two codes through the 75% reported together screen: 37201 *transcatheter therapy, infusion for thrombolysis other than coronary* and 75896 *transcatheter therapy, infusion, any method (eg thrombolysis other than coronary), radiological supervision and interpretation*. In October 2011, the CPT Editorial Panel created four new codes (37211-4) to describe transcatheter therapy for thrombolysis bundled with radiologic supervision and interpretation and Evaluation and Management services. In January 2012, the specialty societies requested deferment of this family of services due to late CPT changes that expanded the number of codes; the continued questions about CPT guideline text, descriptors, and parentheticals; and the imprecision of the 000-day global survey instrument to accurately survey these codes. The Research Subcommittee approved a modified 000-day global survey instrument to be used to survey this family at the RUC meeting in April 2012.

37211 ***Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day***
The RUC reviewed the survey data from 50 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 9 minutes, for proper positioning and additional evaluation necessary for selection and verification of numerous supplies and equipment. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service.

The RUC reviewed the survey's estimated work values and agreed with the specialty society that 8.00 work RVUs, the survey's 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC compared the surveyed code to reference CPT code 93460 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 7.35) and agreed that while the services have comparable work, 37211 should be valued slightly higher due to greater intra-service time, 60 minutes compared to 50 minutes. In addition, the RUC reviewed CPT code 36254 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including*

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arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral (work RVU= 8.15) and agreed that this reference code should be valued slightly higher because it has slightly greater intra-service time compared to the surveyed code, 68 minutes and 60 minutes, respectively. **The RUC recommends a work RVU of 8.00 for CPT code 37211.**

37212 ***Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day***

The RUC reviewed the survey data from 50 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 9 minutes, for proper positioning and additional evaluation necessary for selection and verification of numerous supplies and equipment. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service.

The RUC reviewed the survey's estimated work values and agreed with the specialty society that 7.06 work RVUs, the survey's 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC compared the surveyed code to key reference service 37187 *Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance* (work RVU= 8.03) and agreed that reference code should be valued higher due to greater intra-service time and slightly greater total time, 145 minutes and 138 minutes, respectively. In addition, the RUC reviewed CPT code 93460 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 7.35) and agreed that while the services have comparable work, the surveyed code should be valued lower because it is a less intense and complex service. Finally, the RUC reviewed 37211 in comparison to 37212 and noted that while the two service have identical time, 37212 should be valued lower because the arterial system involved in 37211 has greater intensity due to higher risk for complication compared to the venous infusion code. **The RUC recommends a work RVU of 7.06 for CPT code 37212.**

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37213 ***Transcatheter therapy, arterial other than coronary or venous infusion for thrombolysis, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed***

The RUC reviewed the survey data from 50 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 33 minutes and post-service time= 25 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 2 minutes, for proper positioning to obtain necessary views to treat the lesion. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service. Finally, the specialty discussed that this service includes continued treatment only if the care continues into the third day. This service is not typical, and will be billed only a fraction of the time compared to CPT code 37214, which describes continued care concluded on the second day of care.

The RUC reviewed the survey's estimated work values and agreed with the specialty society that 5.00 work RVUs, the survey's 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC compared the surveyed code to reference CPT code 93452 *Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU= 4.75) and agreed that while the two services are similar services, the surveyed code should be valued slightly higher due to greater intra-service time, 33 minutes and 30 minutes, respectively. In addition, the RUC reviewed CPT code 93455 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography* (work RVU= 5.54) and the reference code should be valued slightly higher due to greater intra-service time compared to 37213. Finally, the RUC compared this service to the base arterial infusion service, 37211, and concurred that 37213 is appropriately valued relative to the family of services. **The RUC recommends a work RVU of 5.00 for CPT code 37213.**

37214 ***Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method***

The RUC reviewed the survey data from 48 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 38 minutes and post-service time= 23 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 2 minutes, for proper positioning to obtain necessary views to treat the lesion. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service. Finally, the specialty discussed that this service includes continued treatment when the thrombolysis is concluded on the second day, which is the typical clinical scenario.

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The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the respondents overestimated the physician work involved in this service. To value this service accurately, the previously billed codes that are now bundled into this procedure (75898 work RVU= 1.65 and 99233 work RVU= 1.39) were summated to obtain a work RVU of 3.04. The RUC agreed that a work RVU of 3.04, below the survey's 25th percentile, is an accurate value for this service. To justify this value, the RUC compared the surveyed code to reference code 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that while 37214 has 8 minutes more intra-service time compared to 36200, the reference code is a more intense procedure and the two services should be valued similarly. In addition, the RUC reviewed CPT code 31630 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture* (work RVU= 3.81) and agreed that the reference code should be valued higher due to greater intra-service time compared to the surveyed code, 45 minutes and 38 minutes, respectively. Finally, the RUC reviewed code 37214 in relation to the family of services and noted that the intensity and complexity of 37214 is much less compared to 37213 and is appropriately valued lower than 37213. **The RUC recommends a work RVU of 3.04 for CPT code 37214.**

The RUC discussed the need to survey CPT codes 75896 *Transcatheter therapy, infusion other than for thrombolysis, radiological supervision and interpretation* and CPT code 75898 *Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis* since the inherent physician work has changed due to CPT Editorial Panel revisions. The specialty explained that these codes will see large utilization shifts into the new bundled codes. The specialty societies have indicated that CPT code 75898 will be addressed in the upcoming Embolization code change proposal to the CPT Editorial Panel in CPT 2013. The specialties will be providing a further recommendation for CPT code 75896 at the October 2012 RUC meeting and the resulting RUC recommendation will be sent to CMS immediately for inclusion in the CY 2013 MPFS Final Rule. **However, until recommendations are provided, the RUC recommends carrier pricing for CPT codes 75896 and 75898.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications by the Practice Expense Subcommittee.

Work Neutrality: The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

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CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
D 37201		~~Transcatheter therapy, infusion for thrombolysis other than coronary~~ (37201 has been deleted. To report see 37211-37214) ~~(For radiological supervision and interpretation, use 75896)~~	000	N/A
⊙#●37211	I1	Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	000	8.00
⊙#●37212	I2	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	000	7.06
⊙#●37213	I3	Transcatheter therapy, arterial other than coronary or venous infusion for thrombolysis, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;	000	5.00
⊙#●37214	I4	cessation of thrombolysis including removal of catheter and vessel closure by any method (Report 37211-37214 once per date of treatment) (For declotting by thrombolytic agent of implanted vascular access device or catheter, use 36593)	000	3.04
D 37209		~~Exchange of a previously placed intravascular catheter during thrombolytic therapy~~ ~~(For radiological supervision and interpretation, use 75900~~) (37209 has been deleted. For exchange of a previously placed intravascular catheter during thrombolytic therapy, see 37211-37214)	000	N/A

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▲75896	I5	Transcatheter therapy, infusion other than for thrombolysis, any ~~method (eg, thrombolysis other than coronary)~~, radiological supervision and interpretation (For radiological supervision and interpretation for thrombolysis other than coronary, see 37211-37214) (Do not report 75896 in conjunction with 37211-37214) *(For infusion for coronary disease, see 92975, 92977)*	XXX	RUC recommends Carrier Pricing
▲75898	I6	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis (For thrombolysis infusion management other than coronary, see 37211-37214) (Do not report 75898 in conjunction with 37211-37214)	XXX	RUC recommends Carrier Pricing
D 75900		~~Exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation~~ ~~(For procedure, use 37209)~~ (75900 has been deleted. For exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation, see 37211-37214)	XXX	N/A
D75961		~~Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation.~~ (75961 has been deleted. To report, use 37211)	XXX	N/A
92975 Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography 92977 by intravenous infusion (For thrombolysis of vessels other than coronary, see ~~37201~~ 37211-37214 ~~75896~~)				

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April 3, 2012

Barbara Levy, MD
Chair, RVS Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60610

Re: Tab 14 Bundle Thrombolysis – 75896/75898

Dear Dr. Levy,

Tab 14 Bundle Thrombolysis is on the agenda for the upcoming April RUC meeting. The genesis of this tab was the identification of CPT code 37201 *Transcatheter therapy, infusion for thrombolysis other than coronary* and 75896 *Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation* in a "Billed Together more than 75% of the time" screen.

This issue was discussed at CPT, where 4 new codes were developed to replace 37201 and 75896. The four new CPT codes were surveyed by a multi-specialty group and recommendations will be presented at the upcoming meeting.

There were two additional codes 75896 *Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation* and 75898 *Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion* listed on the LOI. We included the following note on our LOI "The two orphan S&I codes here 75896 and 75898 follow a similar pattern of our other orphan codes that have come through the RUC recently. It is not suitable to survey them at this time. As such we will be surveying the 4 new codes only." Those codes should remain in their current format in the CPT book until Medicare data are available from the new thrombolysis codes.

Please let us know if you have any questions.

Respectfully,

Gary Seabrook, MD
SVS RUC Advisor

Geraldine McGinty, MD
ACR RUC Advisor

Sean Tutton, MD
SIR RUC Advisor

cc: Sherry Smith
Trisha Crishock
Angela Kim

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37211 Tracking Number I1 Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **8.00**
Global Period: 000 RUC Recommended RVU: **8.00**

CPT Descriptor: Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old man with a right femoral-popliteal bypass presents to the emergency room with a painful, ischemic leg. Physical exam shows absent graft and distal pulses. Motor/sensory exam shows mild sensory deficit, but no motor deficit. The patient is taken to the procedure room where aortogram and runoff angiography exams are performed. (Diagnostic angiography reported separately). Acute thrombosis of the graft is shown, as well as thrombosis of the popliteal artery. Arterial thrombolysis is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 98%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 8%

Description of Pre-Service Work:
• The patient is evaluated.
• A targeted H&P is performed.
• The proposed procedure is discussed with the patient/family and consent is obtained and documented.
• The patient is transported to the procedure room and placed supine on the procedure table.
• Moderate sedation is administered.

Description of Intra-Service Work:
• Monitor the patient for moderate sedation.
• An exchange length guidewire is inserted into the diagnostic catheter and the diagnostic catheter is removed under fluoroscopic guidance.
• Under fluoroscopic guidance a coaxial infusion catheter system is introduced over the guidewire and positioned with the distal tip in the popliteal artery and with the proximal sideholes in the thrombosed fem-pop graft.
• Angiography is performed to document location of catheter and status of runoff vessels.
• The catheters and access sheath are sutured in position at the skin entrance site.
• Bolus injection of thrombolytic agent is performed.
• Thrombolysis infusion is initiated.

Description of Post-Service Work:
• Dressings are applied.
• Moderate sedation post procedure work.
• The patient is transferred from the angio suite to the ICU for care during thrombolysis.
• Appropriate care orders are entered in the electronic medical record.
• The procedure is documented in the chart.
• Procedural imaging is post processed and a permanent record is created for the PACS archive.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.
• Ongoing evaluation and management care is provided in the ICU during the infusion which includes management of thrombolysis dose, anticoagulation, monitoring of appropriate blood levels (e.g. fibrinogen, coagulation studies, etc) and clinical assessment of limb perfusion and access site.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Sean Tutton, MD, Michael Hall, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Geraldine McGinty, MD and Zeke Silva, MD					
Specialty(s):	Vascular Surgery, Interventional Radiology and Diagnostic Radiology					
CPT Code:	37211					
Sample Size:	2528	**Resp N:**	50	**Response:** 1.9 %		
Description of Sample:	SVS - 1953, All US, MD members SIR - 400 randomly selected ACR - 175, randomly selected					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**8.00**	15.00	40.00
Survey RVW:	5.00	8.00	**9.00**	10.00	20.00
Pre-Service Evaluation Time:			**52.50**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**12.50**		
Intra-Service Time:	20.00	45.00	**60.00**	90.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37211	**Recommended Physician Work RVU: 8.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37184	000	8.66	**RUC Time**

CPT Descriptor Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43269	000	8.20	**RUC Time**	19,974

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 37211**	**Key Reference CPT Code:** 37184	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	40.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**138.00**	**160.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	4.11
Urgency of medical decision making	4.64	4.56
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.36	4.22
Physical effort required	4.09	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.82	4.67
Outcome depends on the skill and judgment of physician	4.64	4.67
Estimated risk of malpractice suit with poor outcome	4.18	4.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.09	4.11
Intra-Service intensity/complexity	4.27	4.44
Post-Service intensity/complexity	3.18	3.11

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this code being reviewed?

Code 37211 "Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day" is a new code bundling the work of arterial thrombolysis. This service was previously reported with 37201 "Transcatheter therapy, infusion for thrombolysis other than coronary" (wRVU 4.99), 75896 "Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation" (wRVU 1.31), and 75898 "Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion" (wRVU 1.65). It also bundles all evaluation and management service provided on the same day. These patients require ICU care and the most frequent E&M code would be 99233 "Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit" (wRVU 2.00).

Work RVU Recommendation

We are recommending the 25th percentile from our multispecialty survey, a work RVU of 8.00.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

Clinical Comparison with Key Reference

The key reference service chosen by 22% of survey respondents is 37184 "Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel." This is similar to 37211 in the sense that they are both endovascular procedures performed on occluded arteries. Key differences are that 37184 involves the use of a mechanical device to remove thrombus whereas 37211 only uses pharmacologic means. The addition of a mechanical device adds a significant amount of time to the procedure. In addition, all of the evaluation and management services provides on the same day are also bundled into 37211 but they are not included in 37184.

Work Comparison with Key Reference

The primary differences between 37184 "Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel." and 37211 are the intra-service time, the intensity, and the bundled E&M services. 37184 requires 30 minutes MORE intra-time than 37211 (90 min compared to 60). Otherwise, the two services have the similar pre-time and immediate post-service times. The increased intra-time for 37184 is accounted for by the preparation and use of the mechanical device to remove thrombus from a vessel. 37211 is more intense than 37184 because it involves the initial diagnosis and decision making to treat the problem while 37814 is more technical. 37211 also includes all E&M services provided on the same day while the patient is in the intensive care unit receiving pharmacologic thrombolysis.

Given these similarities, the two codes compare favorably and support our recommended 25th percentile survey value of 8.00.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
37211	8.00	0.105	138	40	3	5	60	30
37184	8.66	0.080	160	20	10	10	90	30

Comparison to MPC codes

Comparison with MPC List Code 1, CPT 43269 – RVW 8.20

43269 "Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent" is a 0-day MPC service with 141 minutes total time, including 40 minutes pre-time and 30 minutes post-time. Both 43269 and 37211 are invasive procedures requiring technical skill to perform successfully. Both 43269 and 37211 have similar of intra-service times (71min vs. 60 min) and very similar IWPUTs (0.0934 vs. 0.105). RVW for 43269 is 8.20 and the major adjustment to estimate an RVW for 37211 from this reference service lies in the pre-service and intra-service times. The difference in intra-service time can be accounted for by subtracting 11 minutes multiplied by the IWPUT for 43269 (11 x 0.0934 = 1.0274) and adding 8 minutes of pre-service time at 0.0224 RVW per minute (8 x 0.0224 = 0.1792).

Thus, the estimated RVW of 37211 should be 8.20 (MPC RVW) + 0.1792 (pre-service adjustment) – 1.0274 (intra-service adjustment) = 7.35. Comparison with this MPC code with very similar time and intensity inputs supports our recommended 25th percentile survey value of 8.00.

Comparison with MPC List Code 1, CPT 31600 – RVW 7.17

31600 "Tracheostomy, planned (separate procedure);" is a 0-day MPC service with 156 minutes total time including 50 minutes pre-time and 66 minutes post-time. Both 31600 and 37211 are procedures requiring technical skill to complete successfully. Both 31600 and 37211 have similar total times and intensities but different distribution of times. RVW for 31600 is 7.17 and the adjustments to estimate an RVW for 37211 from this reference service lies in the pre-, intra- and post-service times. The difference in intra-service time can be accounted for by adding 20 minutes multiplied by the IWPUT for 31600 (20 x 0.1134 = 2.268) and subtracting 38 minutes of pre- and post-service time at 0.0224 RVW per minute (38 x 0.0224 = 0.8512).

Thus, the estimated RVW of 37211 should be 7.17 (MPC RVW) + 2.268 (intra-service adjustment) – 0.8512 (pre- and post-service adjustment) = 8.59. Comparison with this MPC code with very similar time and intensity inputs supports our recommended 25th percentile survey value of 8.00.

In conclusion, our recommended 25th percentile survey value of 8.00 lays nicely between the wRVU for MPC codes 31600 and 43269, both raw and adjusted.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
43269	Endo cholangiopancreatograph	8.20	0.093	141	40			71	30
37211	Thrombolysis, arterial, init day	8.00	0.105	138	40	3	5	60	30
31600	Incision of windpipe	7.17	0.113	156	50			40	66

Additional points of comparison

We find four other codes in the RUC database that further support our recommended 25th percentile survey value of 8.00 for 37211. They are 93460 "Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed", 52345 "Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)", 93461 "Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography", 36254 "Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral", and 52346 "Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)." The table below compares these codes to 37211.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post	RUC reviewed
52345	Cysto/uretero w/up stricture	7.55	0.128	135	45	10	15	45	20	2008
93460	R&I hrt art/ventricle angio	7.35	0.113	128	40	3	5	50	30	2010
37211	Thrombolysis, arterial, init day	8.00	0.105	138	40	3	5	60	30	2012

93461	R&l hrt art/ventricle angio	8.10	0.095	153	45	3	5	65	35	2010
36254	Ins cath ren art 2nd+ bilat	8.15	0.098	139	33	3	5	68	30	2011
52346	Cystouretero w/renal strict	8.58	0.116	140	40	10	10	60	20	2008

Summary
Based on all the above data and comparisons, we believe the 25th percentile survey RVW of 8.00 is appropriate for 37211.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Thrombolysis infusion can occur in any vessel, both arterial and venous. The work required for thrombolysis infusion will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more vascular catheterization codes in addition to the arterial or venous thrombolysis infusion code. This reflects current coding practice and appropriately represents the highly variable work required for thrombolysis of different vessels.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37201, 75896 and 99233

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,062
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The specialty mix is based on the specialty mix in the reference service code 37184.

Specialty Vascular Surgery Frequency 1855 Percentage 23.00 %

Specialty Interventional Surgery Frequency 3225 Percentage 40.00 %

Specialty Cardiology Frequency 1290 Percentage 16.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37184

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37212 Tracking Number I2 Original Specialty Recommended RVU: **7.06**
Presented Recommended RVU: **7.06**
Global Period: 000 RUC Recommended RVU: **7.06**

CPT Descriptor: Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents with sudden onset of a severely swollen and painful left leg. Duplex ultrasound shows acute left leg deep vein thrombosis affecting the femoral vein. Diagnostic venography confirms thrombosis and also demonstrates thrombosis extending to the common iliac vein (venography reported separately). Venous thrombolysis is performed using a popliteal vein approach.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 96%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 10%

Description of Pre-Service Work:
• The patient is evaluated.
• A targeted H&P is performed.
• The proposed procedure is discussed with the patient/family and consent is obtained and documented.
• The patient is transferred from her hospital room to the angiographic suite and placed prone on the angiographic table.
• Moderate sedation is administered.

Description of Intra-Service Work:
• Monitor the patient for moderate sedation.
• An exchange length guidewire is inserted into the diagnostic catheter and the diagnostic catheter is removed under fluoroscopic guidance.
• Under fluoroscopic guidance a coaxial infusion catheter system is introduced over the guidewire and positioned with the distal tip in the inferior vena cava and with the proximal sideholes in the thrombosed vein.
• Angiography is performed to document location of catheter.
• The catheters and access sheath are sutured in position at the skin entrance site.
• Bolus injection of thrombolytic agent is performed.
• Thrombolysis infusion is initiated.

Description of Post-Service Work:
• Dressings are applied.
• Moderate sedation post procedure work.
• The patient is transferred from the angio suite to the ICU for care during thrombolysis.
• Appropriate care orders are written.
• The procedure is documented in the chart.
• Procedural imaging is post processed and a permanent record is created for the PACS archive.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.
• Ongoing evaluation and management care is provided in the ICU during the infusion which includes management of thrombolysis dose, anticoagulation, monitoring of appropriate blood levels (e.g. fibrinogen, coagulation studies, etc) and clinical assessment of venous return and access site.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Sean Tutton, MD, Michael Hall, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Geraldine McGinty, MD and Zeke Silva, MD					
Specialty(s):	Vascular Surgery, Interventional Radiology and Diagnostic Radiology					
CPT Code:	37212					
Sample Size:	2528	**Resp N:**	50	**Response:** 1.9 %		
Description of Sample:	SVS - 1953, All US, MD members SIR - 400 randomly selected ACR - 175, randomly selected					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**8.00**	15.00	50.00
Survey RVW:	3.85	7.06	**8.08**	9.88	15.00
Pre-Service Evaluation Time:			**52.50**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**12.50**		
Intra-Service Time:	15.00	45.00	**60.00**	90.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37212	**Recommended Physician Work RVU: 7.06**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37187	000	8.03	**RUC Time**

CPT Descriptor Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58560	000	6.99	**RUC Time**	64

CPT Descriptor 1 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,809

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 37212**	**Key Reference CPT Code:** 37187	**Source of Time** **RUC Time**
Median Pre-Service Time	48.00	40.00	
Median Intra-Service Time	60.00	85.00	
Median Immediate Post-service Time	30.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**138.00**	**145.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.79	3.69
Urgency of medical decision making	3.86	3.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.07	3.85
Physical effort required	4.07	3.85
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.21	3.92
Outcome depends on the skill and judgment of physician	4.36	4.08
Estimated risk of malpractice suit with poor outcome	3.79	3.62

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.71	3.62
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	3.50	3.15

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this code being reviewed?

Code 37212 "Transcatheter therapy, venous infusion for thrombolysis any method, including radiological supervision and interpretation, initial treatment day" is a new code bundling the work of venous thrombolysis. This service was

previously reported with 37201, "Transcatheter therapy, infusion for thrombolysis other than coronary" (wRVU 4.99), Code 75896 "Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation" (wRVU 1.31), and 75898 "Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion" (wRVU 1.65). It also bundles all evaluation and management service provided on the same day. These patients require ICU care and the most frequent E&M code would be 99233 "Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit" (wRVU 2.00).

Work RVU Recommendation

We are recommending the 25th percentile from our multispecialty survey, a work RVU of 7.06.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

Clinical Comparison with Key Reference

The key reference service chosen by 30% of survey respondents is 37187 "Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance." This is similar to 37212 in the sense that they are both vascular interventions performed on veins for thrombosis. Key differences are that 37187 only involves mechanical thrombectomy while 37212 involves the initial diagnostic exam, decision to perform thrombolysis, and all evaluation and management services provided that day.

Work Comparison with Key Reference

The primary differences between 37187 "Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance" and 37212 lay in the intra-service time and the pre- and post-service times. Code 37187 requires 25 minutes MORE intra-time than 37212 (85 min compared to 60). The pre-service time is longer for 37212 (48 min vs. 40) and the post-service time is longer for 37212 (30 min vs. 20). The increased intra-time for 37187 is accounted for by the preparation and use of the mechanical device to remove thrombus from the vein.

Given these similarities, the two codes compare favorably and support our recommended 25th percentile survey value of 7.06.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
37212	7.06	0.090	138	40	3	5	60	30
37187	8.03	0.080	145	26	5	9	85	20

Comparison to MPC codes

Comparison with MPC List Code 1, CPT 31600 – RVW 7.17

31600 "Tracheostomy, planned (separate procedure);" is a 0-day MPC service with 156 minutes total time including 50 minutes pre-time and 66 minutes post-time. Both 36100 and 37212 are procedures requiring technical skill to complete successfully. Both 31600 and 37212 have similar total times and intensities but different distribution of times. RVW for 36100 is 7.17 and the adjustments to estimate an RVW for 37212 from this reference service lies in the pre-, intra- and post-service times. The difference in intra-service time can be accounted for by adding 20 minutes multiplied by the

IWPUT for 31600 (20 x 0.1134 = 2.268). The difference in pre- and post-service time can be accounted for by subtracting 38 minutes at 0.0224 RVW per minute (38 x 0.0224 = 0.8512).

Thus, the estimated RVW of 37212 should be 7.17 (MPC RVW) + 2.268 (intra-service adjustment) – 0.8512 (pre- and post-service adjustment) = 8.59. Comparison with this MPC code with very similar time and intensity inputs supports our recommended 25th percentile survey value of 7.06.

Comparison with MPC List Code 1, CPT 58560 – RVW 6.99

58560 "Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)" is a 0-day MPC service with 125 minutes total time, including 40 minutes pre-time and 25 minutes post-time. Both 58560 and 37212 are invasive procedures requiring technical skill to perform successfully. 58560 and 37212 have identical intra-service times and very similar IWPUTs (0.0922 vs. 0.090). RVW for 58560 is 6.99 and the major adjustment to estimate an RVW for 37212 from this reference service lies in the pre-service and post-service times. The difference in pre- and post-service times can be accounted for by adding 8 minutes of pre-service time at 0.0224 RVW per minute (8 x 0.0224 = 0.1792) and adding 5 minutes of post-service time at 0.0224 RVW per minute (5 x 0.0224 = 0.112).

Thus, the estimated RVW of 37212 should be 6.99 (MPC RVW) + 0.1792 (pre-service adjustment) + 0.112 (post-service adjustment) = 7.28. Comparison with this MPC code with very similar time and intensity inputs supports our recommended 25th percentile survey value of 7.06.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
31600	Incision of windpipe	7.17	0.113	156	50			40	66
37212	Thrombolysis, vein, init day	7.06	0.090	138	40	3	5	60	30
58560	Hysteroscopy resect septum	6.99	0.092	125	40			60	25

In conclusion, our recommended 25th percentile survey value of 7.06 lays nicely between the wRVU for MPC codes 36100 and 58560, both raw and adjusted.

Additional points of comparison

We find four other codes in the RUC database that further support our recommended 25th percentile survey value of 7.06 for 37212. They are 31545 "Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)", 36475 "Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated", 93460 "Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed.", and 52345 "Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)" The table below compares these codes to 37212.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post	RUC reviewed
31545	Remove vc lesion w/scope	6.30	0.069	154	40	10	10	60	34	2004
36475	Endovenous rf 1st vein	6.72	0.075	159	40	10	15	60	34	2004
37212	Thrombolysis, vein, init day	7.06	0.090	138	40	3	5	60	30	2012
93460	R&I hrt art/ventricle angio	7.35	0.114	128	40	3	5	50	30	2010
52345	Cysto/uretero w/up stricture	7.55	0.128	153	45	10	15	45	20	2008

Summary

Based on all the above data and comparisons, we believe the 25th percentile survey RVW of 7.06 is appropriate for 37212.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Thrombolysis infusion can occur in any vessel, both arterial and venous. The work required for thrombolysis infusion will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more vascular catheterization codes in addition to the arterial or venous thrombolysis infusion code. This reflects current coding practice and appropriately represents the highly variable work required for thrombolysis of different vessels.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37201, 75894 and 99233

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,374
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The specialty mix is based on the specialty mix in the reference service code 37184.

Specialty Vascular Surger Frequency 1237 Percentage 23.01 %

Specialty Interventional Radiology Frequency 2150 Percentage 40.00 %

Specialty Cardiology Frequency 860 Percentage 16.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37184

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37213 Tracking Number I3 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: 000 RUC Recommended RVU: **5.00**

CPT Descriptor: Transcatheter therapy, arterial other than coronary or venous infusion for thrombolysis, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old man with an occluded right femoral-popliteal bypass had thrombolysis infusion started the prior day. He has been managed in the intensive care unit overnight. He undergoes follow-up angiography which demonstrates a residual thrombus. A catheter exchange is performed and thrombolytic infusion is resumed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 96%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 10%

Description of Pre-Service Work:
• Ongoing evaluation and management care is provided which includes management of thrombolysis dose,
• The patient is transferred from his hospital room to the angiographic suite and placed on the angiographic table.
• Clinical assessment of the patient includes evaluation of extremity perfusion, as well as motor/sensory exam of the affected leg.
• Moderate sedation is administered.

Description of Intra-Service Work:
• Monitor the patient for moderate sedation.
• Thrombolytic infusion is temporarily stopped.
• Contrast is injected through the infusion catheter and angiography is performed, studying the area that is being infused.
• Angiography shows partial success in clot dissolution. The decision is made to exchange the infusion catheter and advance the tip further down the graft. The dressings at the catheter site are removed, and the area is prepped and draped.
• Over a guidewire the existing catheter is removed and exchanged for a replacement.
• Angiography is performed to confirm correct catheter tip position, and to ensure that catheter exchange has not altered the clot position.
• The catheter and access sheath are re-sutured in position at the skin entrance site.
• The catheter and access sheath side-arm are connected to infusion pumps.
• Thrombolysis infusion is re-started.

Description of Post-Service Work:
• Dressings are applied.
• Moderate sedation post procedure work.
• The patient is transferred from the angio suite to the ICU for continued care during thrombolysis.
• Appropriate care orders are written.
• The procedure is documented in the chart.
• Procedural imaging is post processed and a permanent record is created for the PACS archive.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.
• Ongoing evaluation and management care is provided in the ICU during the infusion which includes management of thrombolysis dose, anticoagulation, monitoring of appropriate blood levels (e.g. fibrinogen, coagulation studies, etc) and clinical assessment of limb perfusion and access site.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Sean Tutton, MD, Michael Hall, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Geraldine McGinty, MD and Zeke Silva, MD					
Specialty(s):	Vascular Surgery, Interventional Radiology and Diagnostic Radiology					
CPT Code:	37213					
Sample Size:	2528	**Resp N:**	50	**Response:** 1.9 %		
Description of Sample:	SVS - 1953, All US, MD members SIR - 400 randomly selected ACR - 175, randomly selected					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	20.00	50.00
Survey RVW:	2.93	5.00	**6.00**	7.00	15.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	30.00	**33.00**	60.00	120.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37213	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**33.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36521	000	5.35	**RUC Time**

CPT Descriptor Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45385	000	5.30	**RUC Time**	640,634

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 16.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 37213**	**Key Reference CPT Code:** 36521	**Source of Time** **RUC Time**
Median Pre-Service Time	41.00	41.00	
Median Intra-Service Time	33.00	45.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**99.00**	**116.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.22
Urgency of medical decision making	3.22	3.11
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.56	3.67
Physical effort required	3.56	3.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.11	3.67
Outcome depends on the skill and judgment of physician	4.22	4.00
Estimated risk of malpractice suit with poor outcome	3.89	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.11
Intra-Service intensity/complexity	3.89	3.33
Post-Service intensity/complexity	3.44	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this code being reviewed?

Code 37213, Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; is a new code bundling the subsequent day work of arterial or venous thrombolysis. This service was previously reported with 37209, Exchange of a previously placed intravascular catheter during thrombolytic therapy (wRVU 2.27), 75898, Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion (wRVU 1.65), and 75900, Exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation (wRVU 0.49). It also bundles all evaluation and management service provided on the same day. These patients require ICU care and the most frequent E&M code would be 99233, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit (wRVU 2.00).

Work RVU Recommendation

We are recommending the 25th percentile from our multispecialty survey, a work RVU of 5.00.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

Clinical Comparison with Key Reference

The key reference service chosen by 20% of survey respondents is 36521 "Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s)." This is similar to 37213 in the sense that they are both vascular interventions. Key differences are that 3625 is a first-order diagnostic code whereas 37213 is an interventional code with likely higher order selective catheter placement.

Work Comparison with Key Reference

The primary differences between 36521 "Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s)." and 37213 are that 36251 has more intra-service time, and more post-service time but a lower intensity. There is less intra-service than key reference 36251 (33 min compared to 45). Otherwise, the two services have the identical pre-service and similar immediate post-service time.

Given these similarities, the two codes compare favorably and support our recommended 25th percentile survey value of 5.00 wRVUs.

CPT	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
37213	5.00	0.109	99	33	3	5	33	25
36251	5.35	0.085	116	33	3	5	45	30

Comparison to MPC codes

Comparison with MPC List Code 1, CPT 52276 – RVW 4.99

52276 "Cystourethroscopy with direct vision internal urethrotomy)" is a 0-day MPC service with 95 minutes total time including 30 minutes pre-time and 30 minutes post-time. Both 52276 and 372X3 are procedures requiring technical skill to complete successfully. Both 52276 and 37213 have similar total times and intensities but different distribution of times. RVW for 52276 is 4.99 and the adjustments to estimate an RVW for 372X3 from this reference service lies in the pre-, intra- and post-service times. The difference in intra-service time can be accounted for by adding 2 minutes multiplied by the IWPUT for 52276 (2 x 0.1042 = 0.2084). The difference in pre- and post-service time can be accounted for by adding 3 minutes at 0.0224 RVW per minute (3 x 0.0224 = 0.0672).

Thus, the estimated RVW of 37212 should be 4.99 (MPC RVW) + 0.2084 (intra-service adjustment) + 0.0672 (pre- and post-service adjustment) = 5.27. Comparison with this MPC code with very similar time and intensity inputs supports our recommended 25th percentile survey value of 5.00.

Comparison with MPC List Code 1, CPT 45385 – RVW 5.30

45385 "Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique" is a 0-day MPC service with 74 minutes total time, including 16 minutes pre-time and 15 minutes post-time. Both 45385 and 37212 are invasive procedures requiring technical skill to perform successfully. 45385 and 372X2 have similar intra-service times and very similar IWPUTs (0.1071 vs. 0.109). RVW for 45385 is 5.30 and the major adjustment to estimate an RVW for 37213 from this reference service lies in the pre-, intra- and post-service times. The difference in intra-service time can be accounted for by subtracting 10 minutes multiplied by the IWPUT for 45385 (10 x 0.1071 = 1.071). The difference in pre- and post-service times can be accounted for by adding 32 minutes at 0.0224 RVW per minute (32 x 0.0224 = 0.7168).

Thus, the estimated RVW of 37213 should be 5.30 (MPC RVW) - 1.071 (intra-service adjustment) + 0.7168 (pre- and post-service adjustment) = 4.95. Comparison with this MPC code with very similar time and intensity inputs supports our recommended 25th percentile survey value of 5.00.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
52276	Cystoscopy and treatment	4.99	0.104	95	30			35	30
37213	Continue thrombolysis, subseq day	5.00	0.109	99	33	3	5	33	25
45385	Lesion removal colonoscopy	5.30	0.107	74	16			43	15

In conclusion, our recommended 25th percentile survey value of 5.00 lays nicely between the wRVU for MPC codes 52276 and 45385, both raw and adjusted.

Additional points of comparison

We find four other codes in the RUC database that further support our recommended 25th percentile survey value of 5.00 for 37213. They are 43246 "Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube", 93452 "Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed", 59070 "Transabdominal amnioinfusion, including ultrasound guidance", and 93455 "Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography" The table below compares these codes to 37213.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post	RUC reviewed
43246	Place gastrostomy tube	4.32	0.075	106	35	8	5	38	20	2005
93452	Left hrt cath w/ventrclgrphy	4.75	0.102	108	40	3	5	30	30	2010
37213	Continue thrombolysis, subseq day	5.00	0.109	99	33	3	5	33	25	**2012**
59070	Transabdom amnioinfus w/us	5.24	0.109	125	40	15	10	30	30	2003
93455	Coronary art/grft angio s&i	5.54	0.094	123	45	3	5	40	30	2010

Summary

Based on all the above data and comparisons, we believe the 25th percentile survey RVW of 5.00 is appropriate for 37213.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37209, 75898, 75900 and 99233

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,230
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The specialty mix is based on the specialty mix in the reference service code 37184.

Specialty Vascular Surgery Frequency 610 Percentage 23.01 %

Specialty Interventional Radiology Frequency 1060 Percentage 40.00 %

Specialty Cardiology Frequency 424 Percentage 16.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37184

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37214 Tracking Number I4 Original Specialty Recommended RVU: **3.04**
Presented Recommended RVU: **3.04**
Global Period: 000 RUC Recommended RVU: **3.04**

CPT Descriptor: Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old man with an occluded right femoral-popliteal bypass has been treated by continuous infusion of thrombolysis for 2 days. He is clinically improved, and there is no longer evidence of leg ischemia. He undergoes follow-up angiography which demonstrates successful thrombolysis. The catheter is removed and vessel closed.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 8%

Description of Pre-Service Work:
• Ongoing evaluation and management care is provided which includes management of thrombolysis dose.
• The patient is transferred from his hospital room to the angiographic suite and placed on the angiographic table.
• Clinical assessment of the patient includes evaluation of extremity perfusion, as well as motor/sensory exam of the affected leg.
• Moderate sedation is administered.

Description of Intra-Service Work:
• Moderate sedation is monitored.
• Thrombolytic in fusion is temporarily stopped.
• Contrast is injected through the infusion catheter and angiography is performed, studying the area that is being infused.
• Angiography shows completed therapy.
• The infusion catheter is removed.
• Hemostasis obtained with manual compression, closure device, or standard closure of the arteriotomy.

Description of Post-Service Work:

• Dressings are applied.
• Moderate sedation post procedure work.
• The patient is transferred from the angio suite to the ICU for continued care during thrombolysis.
• Appropriate care orders are written.
• The procedure is documented in the chart.
• Procedural imaging is post processed and a permanent record is created for the PACS archive.
• A formal report including image interpretation is dictated, transcribed, edited, and authenticated for archival in the permanent medical record.
• The procedural findings and treatment plans are discussed with the patient, family, and referring medical team.
• Ongoing evaluation and management care is provided which includes anticoagulation, monitoring of appropriate blood levels (e.g. fibrinogen, coagulation studies, etc) and clinical assessment of limb perfusion and access site.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Sean Tutton, MD, Michael Hall, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Geraldine McGinty, MD and Zeke Silva, MD					
Specialty(s):	Vascular Surgery, Interventional Radiology and Diagnostic Radiology					
CPT Code:	37214					
Sample Size:	2528	**Resp N:**	48	**Response:** 1.8 %		
Description of Sample:	SVS - 1953, All US, MD members SIR - 400 randomly selected ACR - 175, randomly selected					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	16.00	50.00
Survey RVW:	3.00	4.99	**5.55**	7.00	15.00
Pre-Service Evaluation Time:			**17.50**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	20.00	**38.00**	60.00	120.00

Immediate Post Service-Time:	**23.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37214	**Recommended Physician Work RVU: 3.04**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**38.00**		

Immediate Post Service-Time:	**23.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36251	000	5.35	**RUC Time**

CPT Descriptor Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45378	000	3.69	**RUC Time**	758,465

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 37214**	**Key Reference CPT Code:** 36251	**Source of Time** RUC Time
Median Pre-Service Time	41.00	40.00	
Median Intra-Service Time	38.00	45.00	
Median Immediate Post-service Time	23.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	
Median Total Time	**102.00**	**115.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.22
Urgency of medical decision making	3.22	3.11
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.56	3.67
Physical effort required	3.56	3.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.11	3.67
Outcome depends on the skill and judgment of physician	4.22	4.00
Estimated risk of malpractice suit with poor outcome	3.89	3.69

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.11
Intra-Service intensity/complexity	3.89	3.33
Post-Service intensity/complexity	3.44	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this code being reviewed?

Code 37214 "Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method" is a new code bundling the final day work of arterial or venous thrombolysis. This service was previously reported with 75898 "Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion" (wRVU 1.65), and 99233 "Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication" (wRVU 1.39).

Work RVU Recommendation

We are recommending the existing values, a work RVU of 3.04.

Pre-time

Pre-time package 2b (facility- difficult patient/straightforward procedure with sedation/anesthesia) is appropriate, with modifications to the package positioning time. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. These additional minutes were added to the lower extremity revascularization codes for the same reasons and accepted by the RUC.

Comparison to key reference code

Clinical Comparison with Key Reference

The key reference service chosen by 17% of survey respondents is 36521 "Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s)." This is similar to 37214 in the sense that they are both vascular interventions. Key differences are that 36521 is a first-order diagnostic code whereas 37214 is an interventional code with completion of treatment and closure of the access site.

Work Comparison with Key Reference

The primary differences between 36521 "Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s)." and 37214 are that 36251 has more intra-service time, and more post-service time but a lower intensity. There is less intra-service than key reference 36251 (38 min compared to 45). Otherwise, the two services have the identical pre-service and similar immediate post-service time.

Given these similarities, the two codes compare favorably and support our recommended value of 3.04 wRVUs.

CPT	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
37214	3.04	0.044	102	33	3	5	38	23
36251	5.35	0.085	116	33	3	5	45	30

Comparison to MPC codes

Comparison with MPC List Code 1, CPT 31622 – RVW 2.78

31622 "Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)" is a 0-day MPC service with 65 minutes total time, including 20 minutes pre-time and 15 minutes post-time. Both 31622 and 37214 are invasive procedures requiring technical skill to perform successfully. Both 31622 and 37214 have similar of intra-service times (30 min vs. 38 min). RVW for 31622 is 2.78 and the major adjustment to estimate an RVW for 37214 from this reference service lies in the pre-service and intra-service times. The difference in intra-service time can be accounted for by adding 8 minutes multiplied by the IWPUT for 31622

(8 x 0.0688 = 0.5504) and adding 26 minutes of pre- and post-service time at 0.0224 RVW per minute (26 x 0.0224 = 0.5824).

Thus, the estimated RVW of 37214 should be 2.78 (MPC RVW) + 0.5504 (intra-service adjustment) + 0.5824 (pre- and post-service adjustment) = 3.91. Comparison with this MPC code with very similar intra-service time more than supports our recommended value of 3.04.

Comparison with MPC List Code 1, CPT 45378 – RVW 3.69

45378 "Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)" is a 0-day MPC service with 75 minutes total time including 30 minutes pre-time and 15 minutes post-time. Both 45378 and 37214 are procedures requiring technical skill to complete successfully. Both 45378 and 37214 have similar intra-service times. RVW for 45378 is 3.69 and the adjustments to estimate an RVW for 37214 from this reference service lies in the pre-, intra- and post-service times. The difference in intra-service time can be accounted for by adding 8 minutes multiplied by the IWPUT for 45378 (8 x 0.0917 = 0.7336) and adding 16 minutes of pre- and post-service time at 0.0224 RVW per minute (16 x 0.0224 = 0.3584).

Thus, the estimated RVW of 37214 should be 3.69 (MPC RVW) + 0.7336 (intra-service adjustment) + 0.3584 (pre- and post-service adjustment) = 4.782. Comparison with this MPC code with very similar time supports our recommended value of 3.04.

In conclusion, our recommended value of 3.04 lays nicely between the wRVU for MPC codes 31622 and 45378.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
31622	Dx bronchoscope/wash	2.78	0.069	65	10	5	5	30	15
37214	End thrombolysis, remov cath	3.04	0.044	102	33	3	5	38	23
45378	Diagnostic colonoscopy	3.69	0.092	75	20	5	5	30	15

Additional points of comparison

We find four other codes in the RUC database that further support our recommended value of 3.04 for 37214. They are 51729 "Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique", 12007 "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm", 49446 "Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report" and 31630 "Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture." The table below compares these codes to 37214.

CPT	DESC	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post	RUC reviewed
51729	Cystometrogram w/vp&up	2.51	0.043	75	20	0	0	40	15	2006
12007	Repair superficial wound(s)	2.90	0.071	54	8	2	1	35	8	2010
36200	Place catheter in aorta	3.02	0.058	91	33	3	5	30	20	2011
37214	End thrombolysis, remov cath	3.04	0.044	102	33	3	5	38	23	2012
49446	Change g-tube to g-j perc	3.31	0.055	93	25	8	5	40	15	2007
31630	Bronchoscopy dilate/fx repr	3.81	0.050	125	20	15	15	45	30	2003

Summary

Based on all the above data and comparisons, we believe the RVW of 3.04 is appropriate for 37214.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. There is a possibility that a patient will have a stenosis identified after clot dissolution and would benefit from either an endovascular intervention or open surgical revascularization that may be done on the same day or a subsequent date (same hospitilization).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75898 and 99232

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
13,436 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The specialty mix is based on the specialty mix in the reference service code 37184.

Specialty Vascular Surgery Frequency 3091 Percentage 23.00 %

Specialty Interventional Radiology Frequency 5375 Percentage 40.00 %

Specialty Cardiology Frequency 2150 Percentage 16.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37184

ISSUE: Thrombolysis

TAB: 15

						RVW					Total	PRE			INTRA					POST-	SURVEY EXPERIENCE				
SOURCE	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	MIN	25th	MED	75th	MAX
REF (2005)	37184	Primary percutaneous transluminal mechanical throm	11	0.080			8.66			160	20	10	10			90			30					
CURRENT	37201	Transcatheter therapy, infusion for thrombolysis othe		0.037			4.99			181	30	15	20			81			35					
CURRENT	75896	Transcatheter therapy, infusion, any method (eg, thro		0.052			1.31			25						25								
CURRENT	75898	Angiography through existing catheter for follow-up st		0.000						31						31								
CURRENT	99233	Subsequent hospital care, per day, for the evaluation		0.048			2.00			55	10					30			15					
SVY	37211	Transcatheter therapy, arterial infusion for thrombolys	50	0.114	5.00	8.00	9.00	10.00	20.00	165	53	10	13	20	45	60	90	120	30	0	4	8	15	40
REC				0.105			8.00			138	40	3	5			60			30					
REF (2005)	37187	Percutaneous transluminal mechanical thrombectomy	15	0.080			8.03			145	26	5	9			85			20					
CURRENT	37201	Transcatheter therapy, infusion for thrombolysis othe		0.037			4.99			181	30	15	20			81			35					
CURRENT	75896	Transcatheter therapy, infusion, any method (eg, thro		0.052			1.31			25						25								
CURRENT	75898	Angiography through existing catheter for follow-up st		0.000						31						31								
CURRENT	99233	Subsequent hospital care, per day, for the evaluation		0.048			2.00			55	10					30			15					
SVY	37212	Transcatheter therapy, venous infusion for thromboly	50	0.098	3.85	7.06	8.08	9.88	15.00	165	53	10	13	15	45	60	90	123	30	0	5	8	15	50
REC				0.090			7.06			138	40	3	5			60			30					
REF (2011)	36251	Selective catheter placement (first-order), main renal	10	0.085			5.35			116	33	3	5			45			30					
CURRENT	37209	Exchange of a previously placed intravascular cathet		0.061			2.27			50	10					30			10					
CURRENT	75898	Angiography through existing catheter for follow-up st		0.053			1.65			31						31								
CURRENT	75900	Exchange of a previously placed intravascular cathet		0.009			0.49			44	3					38			3					
CURRENT	99233	Subsequent hospital care, per day, for the evaluation		0.048			2.00			55	10					30			15					
SVY	37213	Transcatheter therapy, arterial or venous infusion for	50	0.148	2.93	5.00	6.00	7.00	15.00	93	15	10	10	15	30	33	60	120	25	0	5	10	20	50
REC				0.109			5.00			99	33	3	5			33			25					
REF (2011)	36251	Selective catheter placement (first-order), main renal	8	0.085			5.35			116	33	3	5			45			30					
CURRENT	75898	Angiography through existing catheter for follow-up st		0.053			1.65			31						31								
CURRENT	99232	Subsequent hospital care, per day, for the evaluation		0.047			1.39			40	10					20			10					
SVY	37214	Transcatheter therapy, arterial or venous infusion for	48	0.116	3.00	4.99	5.55	7.00	15.00	98	18	10	10	10	20	38	60	120	23	0	5	10	16	50
REC				0.044			3.04			102	33	3	5			38			23					

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day

37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed

37214 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method

Global Period: 000 **Meeting Date:** April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus committee including SVS, SIR, and ACR members discussed practice expense details for codes 37211-37214.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

We used CPT code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* as a reference code. CPT 37182 was reviewed by the RUC in Feb 2002.

The typical patient for 37211 and 37212 would present to the hospital emergency room and therefore we are not requesting pre-service clinical staff time. The patient will remain in the hospital; therefore, post-service clinical staff time does not apply.

The typical patient for 37213 and 37214 is already in the hospital. We are requesting pre time for scheduling space and equipment in the hospital for 37213 and 37214. We are also requesting 3 post service minutes in 37214 for phone calls.

Pre-Service Clinical Labor Activities:
Schedule space and equipment in facility

Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities:
Conduct phone calls/call in prescriptions

CPT Code: 37211-37214
Specialty Society('s): SVS, ACR, SIR

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day

37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed

37214 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method

Global Period: 000 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus committee including SVS, SIR, and ACR members discussed practice expense details for codes 37211-37214. It was determined that these services will not be provided in a non-facility setting. Therefore we recommend zero non-facility direct expense details for these four codes.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A
Service Clinical Labor Activities: N/A
Post-Service Clinical Labor Activities: N/A

	A	B	C	D	E	F	G	H	I	J	K	L	M
1			AMA Specialty Society Recommendation	REFERENCE CODE									
2				37182		37211		37212		37213		37214	
3	**Meeting Date: 04/20012** **Tab: 36** **Specialty: SVS, SIR and ACR**	**CMS Code**	**Staff Type**	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS)		Thrombolysis, arterial, init day		Thrombolysis, vein, init day		Continue thrombolysis, subseq day		End thrombolysis, remov cath	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**												
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**18.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		**5**								
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		**5**								
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**5**								
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available												
22	Obtain vital signs												
23	Provide pre-service education/obtain consent												
24	Prepare room, equipment, supplies												
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV												
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure												
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains												
32	Clean room/equipment by physician staff												
33	Clean Scope												
34	Clean Surgical Instrument Package												
35	Complete diagnostic forms, lab & X-ray requisitions												
36	Review/read X-ray, lab, and pathology reports												
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
38	Other Clinical Activity - *specify:*												
42	**End: Patient leaves office**												
43	**POST-SERVICE Period**												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		**3**								
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*												
54	**End: with last office visit before end of global period**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack										
57													
58													
59													
60													
61													
62	**EQUIPMENT**	**CODE**											
63													
64													
65													
66													
67													

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Codes Reported Together 75% or More Screen

September 2011

Transcath Retrieval Intravascular Foreign Body

In 2010, the RUC's Relativity Assessment Workgroup identified the code pair *37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)* and 75940 *Percutaneous placement of IVC filter, radiological supervision and interpretation* and 36010 *Introduction of catheter, superior or inferior vena cava* billed together more than 75% of the time according to 2009 Medicare claims data. In February 2011, the CPT Editorial Panel created four new codes to bundle the services together. In April 2011, three new codes 37191, 37192 and 37193 were surveyed and reviewed by the RUC. However, one code 37197 *Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed* was held for survey for the September 2011 RUC meeting.

The RUC reviewed the survey results from 69 practicing physicians and agreed with the specialty that the survey's median physician time components as follows: pre-service time of 41 minutes, intra-service time of 60 minutes and post-service time of 20 minutes. The RUC also reviewed the survey's estimated work values and disagreed that the median work RVU of 8.00 was an accurate valuation for the typical physician work involved. The RUC did not agree that this service reflected the same work as 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU= 7.99). However, the RUC understands that the easier patients will be reported under the new IVC filter code 37193 *Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* leaving an increase in intensity of patients for 37197.

To find an appropriate value, the RUC compared the surveyed code to CPT code 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU= 6.72) and agreed that the two service have highly similar intra-service work, and identical time of 60 minutes. Given that these service are so similar, the RUC agreed that 37197 should be directly crosswalked to 36475. For additional reference, 37197 was compared to CPT

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code 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated* (work RVU= 6.72) and the RUC agreed that the two services should be valued identically, due to analogous physician work and intra-service time, 55 minutes and 60 minutes, respectively. Finally, to ensure a work RVU of 6.72 is accurate, the RUC took the median survey of 8.00 work RVUs and backed out the introduction service, 36013 *Introduction of catheter, right heart or main pulmonary artery* (work RVU= 1.26), adjusted for multiple procedure reduction). The resulting work RVU of 6.74 is an accurate value for the physician work involved in 37197, providing an additional level of validation for the recommended work RVU of 6.72 (a direct crosswalk to 36475). **The RUC recommends a work RVU of 6.72 for CPT code 37197.**

Practice Expense
The RUC accepted the direct practice expense inputs recommended by the specialty and made minor modifications to the equipment to align with the revised moderate sedation equipment guidelines.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code (●New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
⦿37191		Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed (For open surgical interruption of the inferior vena cava through a laparotomy or retroperitoneal exposure, use 37619)	000	4.71 (RUC Recommended Value from April 2011 Meeting)

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⦿37192		Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed (Do not report 37192 in conjunction with 37191)	000	8.00 (RUC Recommended Value from April 2011 Meeting)
⦿37193		Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed (Do not report 37193 in conjunction with ~~37203,~~ 37197)~~75961)~~	000	8.00 (RUC Recommended Value from April 2011 Meeting)
~~⦿37203~~		~~Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)~~ ~~(For radiological supervision and interpretation, use 75961)~~ (37203 has been deleted. To report, use 37197) (For removal of a vena cava filter, use 37193)	000	N/A
⦿●37197	A1	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed (For percutaneous retrieval of a vena cava filter, use 37193)	000	6.72
Radiology **Diagnostic Radiology (Diagnostic Imaging)** **Vascular Procedures** **Transcatheter Procedures**				

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~~75961~~		~~Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation~~ ~~(For procedure, use 37203)~~ (75961 has been deleted. To report, use 37197) *(For removal of a vena cava filter, use 37193)*	000	N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37197 Tracking Number Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **8.00**
Global Period: 000 RUC Recommended RVU: **6.72**

CPT Descriptor: Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed. (For percutaneous retrieval of a vena cava filter, use (37193)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old woman with metastatic breast cancer has a fractured venous catheter related to her indwelling venous port. The catheter fragment has migrated to the right ventricle, and the distal tip is in the main pulmonary artery. Catheter fragment retrieval is performed from a percutaneous femoral vein approach.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 87%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 75%

Description of Pre-Service Work: The physician reviews the patient signs and symptoms, physical findings, medical/operative history and available diagnostic studies. The physician then assesses venous access options and estimates the range of sheaths, guidewires, catheters, and dilators that may be required, and ensures availability. Additional physician work includes: assess need for stand-by devices that might be needed emergently (e.g. crash cart), review results of recent laboratory testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. The patient is reexamined to make sure that physical findings have not changed and the H&P is updated. The physician discusses procedure plan in detail, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites and record presence/absence of distal pulses, capillary refill, and severity of lower extremity edema bilaterally. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the planned procedure, techniques, and all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been established. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The location of the access vessel (common femoral vein) is determined with palpation of the adjacent common femoral artery. Superficial and deep local anesthesia is administered. Using Seldinger technique, the access vessel is punctured and a guidewire is advanced. Serial 4 and 5 Fr dilators are passed and an 8 French vascular sheath is placed into the accessed common

femoral vein. A second guidewire is placed, the 8 Fr sheath is removed, and the sheath is replaced over one of the guidewires (leaving the second wire external to the sheath). A guide catheter is manipulated centrally into the heart adjacent to the foreign body fragment. The coaxial wire is removed and a snare is placed through the guide catheter. The guide catheter and snare combination are used to capture the foreign body fragment in the snare under fluoroscopic guidance. When captured, the fragment is firmly gripped in the snare/guide catheter system. The fragment and guide/snare system are retracted to the sheath. The sheath and fragment/guide/snare are removed as a unit leaving the safety wire in position. The fragment is inspected to judge completeness of removal. The chest is fluoroscopically evaluated to assure no remaining catheter fragments are present. The safety guide wire is removed. Manual compression is utilized for closure of the venotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. Assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Dictate complete procedure note. Repeat patient exam and assessment of vital signs and lower extremity perfusion multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up physician encounter, labs, and additional diagnostic studies or therapeutic procedures as indicated. The patient is transferred to an appropriate inpatient care setting or discharged to home when recovery area discharge criteria are met. Discharge or admission/transfer orders are completed. All appropriate medical records are completed, with copy to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Gary Seabrook, MD, Mathew Sideman, MD, Michael Sutherland, MD, Robert Vogelzang, MD, Gerald Niedzwiecki, MD, Michael Hall, MD, Geraldine McGinty, MD and Zeke Silva, MD		
Specialty(s):	Vascular Surgery, Interventional Radiology and Radiology		
CPT Code:	37197		
Sample Size: 600	**Resp N:** 69	**Response:** 11.5 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	40.00
Survey RVW:	3.59	5.00	**8.00**	9.00	12.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	45.00	**60.00**	60.00	360.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37197	**Recommended Physician Work RVU: 8.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36595	000	3.59	**RUC Time**

CPT Descriptor Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43269	000	8.20	**RUC Time**	20,220

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	37,788

CPT Descriptor 2 Tracheostomy, planned (separate procedure);

Other Reference CPT Code	Global	Work RVU	Time Source
37183	000	7.99	**RUC Time**

CPT Descriptor Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 36.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 37197**	**Key Reference CPT Code:** 36595	**Source of Time** **RUC Time**
Median Pre-Service Time	41.00	30.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**121.00**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.16	2.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.96	2.36
Urgency of medical decision making	3.92	2.48
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.32	2.96
Physical effort required	3.68	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.16	2.68
Outcome depends on the skill and judgment of physician	4.28	2.96
Estimated risk of malpractice suit with poor outcome	4.04	2.72

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.12	2.64
Intra-Service intensity/complexity	4.00	3.24
Post-Service intensity/complexity	2.72	2.44

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 37197 (*Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed*) is a new bundled code which resulted from the parent codes being identified through the "codes reported together 75% or more" screen. The new code is similar to the IVC retrieval code created during the recent restructuring of the IVC filter codes. The surveyed code 37197 consists of a complex venous intervention in which an intravascular foreign body is secured and retrieved. Wires, catheters, and endovascular devices are placed into the peripheral vasculature, heart, and pulmonary artery. In addition, this code describes the work of explanting a foreign body (example: catheter fragment). The intervention is intense, and potential complications, including acute cardiac arrhythmia, are significant.

IVC retrieval was previously reported with component coding as 37203 (*Transcatheter retrieval, percutaneous, of intravascular foreign body*) with an intra-service time of 80 minutes (RVW 5.02) and 75961 (*Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation*), (RVW 4.24) resulting in a cumulative RVW of 9.26. Code 37203 was frequently utilized to report IVC filter retrieval. The IVC filter codes have been restructured for CPT 2012 and filter removal is now a bundled code, reviewed by the RUC in April 2011 with an intra-time of 60 minutes and RUC recommended RVW of 8.00. The physician activity involved with the new bundled code and the current surveyed code (37197) is very similar in that large vascular access sheaths and endovascular retrieval devices are employed to remove a foreign body from the central venous system. The multidisciplinary survey results from 37197 reflect significant similarity between this new code and the recently RUC evaluated IVC filter retrieval code. The multidisciplinary expert consensus panel concluded that these codes are technically very similar based on magnitude estimation.

A multi-specialty survey with 69 respondents was completed for 37197. 91% of the respondents indicated the vignette was typical. The survey median intra-service time was 60 minutes and median RVW was 8.00.

Pre-time

Pre-time package 2B (Facility- Difficult Patient/Straightforward Procedure - With sedation/anesthesia care) is appropriate with the addition of 2 minutes to the positioning time to permit imaging and movement of monitors and wires/lines in the radiographic field.

Comparison to key reference codes

The most frequent reference code chosen by survey respondents was 36595 (*Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access*) with an intra-service time of 45 minutes and RVW of 3.59. This is now reported with the S&I code 75901 (*Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation*) with an RVW of 0.49) for cumulative RVW of 4.08. CPT code 36595 is technically similar to 37197 in that an endovascular retrieval device is deployed into the venous system, however there are significant differences between 36595 and 37197. The survey respondents rated 36595 to have lesser complexity and intensity, mental effort and judgment, as well as technical skill/physical effort than 37197. It is the consensus of the expert panel that the survey respondents took these differences into account when estimating work RVU of 37197 relative to those provided in the key reference code. Code 37197 vignette involves selective catheterization of the right heart and pulmonary arteries whereas 36595 describes a direct inline access from the IVC into the SVC. The size of venous access is typically smaller for 36595, since only pericatheter material rather than larger foreign bodies are removed. Moderate sedation is included in the pre-time work for 37197 and is not for 36595.

Mod Sed?	CPT	Glob	RVW	Total Time	EVAL	POSIT	SDW	INTRA	POST
No	**36595**	000	3.59	90	30			45	15
Yes	**37197**	000	8.00	121	33	3	5	60	20

37183 (*Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation*) with an intra-service time of 77.5 minutes and RVW of 7.99 was the second most frequently selected reference code in this survey. The surveyed respondents rated 37183 to have similar complexity and intensity, mental effort and judgment, as well as technical skill/physical effort than the surveyed code. Code 37183 is also a bundled service and is technically similar to 37197 in that large access sheaths are introduced into the vascular system and branches arising from the SVC/IVC are selected to perform an intervention.

Mod Sed?	CPT	Glob	RVW	Total Time	EVAL	POSIT	SDW	INTRA	POST
Yes	**37183**	000	7.99	135	27.5			77.5	30
Yes	**37197**	000	8.00	121	33	3	5	60	20

The multidisciplinary expert consensus recommends the median values for time and RVW (8.00). Median time and RVU values accurately reflect the physician work and complexity of intervention. The survey values are supported by the key reference codes. The work is analogous to the recently RUC reviewed filter removal code (372X3).

Mod Sed?	CPT	Glob	RVW	Total Time	EVAL	POSIT	SDW	INTRA	POST
Yes	**372x3**	000	8.00	116	33	3	5	60	15
Yes	**37197**	000	8.00	121	33	3	5	60	20

Comparison to MPCs:
CPT Code 372X1 is also appropriately placed relative to MPC codes 31600 and 43269.

	CPT	DESC	GLOB	RVW	Total Time	eval	pos	s,d,w	INTRA	sd-im
MPC	**31600**	*Tracheostomy, planned*	000	**7.17**	156	50			40	66
	37197	***Transcatheter retrieval, percutaneous, of intravascular foreign body***	**000**	**8.00**	**121**	**33**	**3**	**5**	**60**	**20**
MPC	**43269**	*ERCP, with endoscopic retrograde removal of foreign body and/or change of tube or stent*	000	**8.20**	141	40			71	30

Recommendations
We recommend a work RVU of 8.00 for CPT Code 37197

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Retrieval of a foreign body can occur in any vessel, both arterial and venous. The work required for retrieval will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more vascular catheterization codes in addition to the retrieval code.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT code 37203 and S&I CPT code 75961

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology How often? Commonly

Specialty Vascular Surgery How often? Commonly

Specialty Interventional Radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1260
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that approximately half of the foreign body retrievals will be for Medicare patients.

Specialty Radiology Frequency 600 Percentage 47.61 %

Specialty Interventional Radiology Frequency 160 Percentage 12.69 %

Specialty Vascular Surgery Frequency 200 Percentage 15.87 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 630
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Foreign Body Retrieval was previously reported with CPT code 37203 (2010-4,214). The RUC made recommendations for new IVC Filter codes at the April 2011 RUC meeting for CY 2012. We estimated that 85% of the 37203s would now be coded with the IVC filter retrieval code and 15% will be coded with this new FBR code 372XX1.

Specialty Radiology Frequency 302 Percentage 47.93 %

Specialty Interventional Radiology Frequency 88 Percentage 13.96 %

Specialty Vascular Surgery Frequency 113 Percentage 17.93 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37183

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptors:

37197 Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed

(For percutaneous retrieval of a vena cava filter, use 37193)

Global Periods: 000 **Meeting Date:** September 2011

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The multispecialty organizations (SIR, ACR, SVS, ACC and SCAI) convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this newly created CPT code.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

We selected CPT code 37193 *Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)* as our comparison code. The procedures, processes and resources are comparable. The RUC and PE Subcommittee approved CPT code 37193 in April 2011.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptors:

37197 Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed

(For percutaneous retrieval of a vena cava filter, use 37193)

Global Periods: 000 **Meeting Date:** September 2011

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The multispecialty organizations (SIR, ACR and SVS) convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this newly created CPT code.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Phone calls & prescriptions
- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

The patient is greeted, gowning is provided and patient is escorted to procedure room. The nurse obtains vital signs, interviews the patient for allergies, medications and coagulopathy. Procedure is explained and informed consent is witnessed. The rad tech prepares the room, equipment and supplies after consulting with the M.D regarding the supplies to be used. The angio tech prepares the back table. IV access is established. The patient is positioned, skin is prepped and the patient is draped. RN administers conscious sedation. The angio tech assists the M.D. performing procedure. The rad tech assists the MD with flouro, contrast, image acquisition, etc. The patient is escorted to the observation area. RN performs sequential vital signs over 4 hour

observation. RT processes the images and completes all the necessary paperwork. The angio tech cleans the room. The patient is given discharge instructions.

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

	A	B	C	D	E	F	G	H	I
1				37913		37197			
2	**Meeting Date: September 2011** **Specialty: SIR, ACR and SVS**	**CMS**	**Staff**	*Retrieval of intravascular vena cava filter* *Approved April 2011 Mtg*		*Transcatheter retrieval, percutaneous, of intravascular foreign body (eg fractured venous or arterial catheter), includes S&I and imaging guidance*			
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**		
4	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**		
5	**TOTAL CLINICAL LABOR TIME**			**298**	**9**	**230**	**9**		
6	*RN*	*L051A*	*RN*	*122*		*122*			
7	*RN/LPN/MTA*	*L037D*	*RN/LPN/MTA*	*45*	*9*	*27*	*9*		
8	*Angio Tech*	*L041A*	*AngioTech*	*74*		*74*			
9	*Angio Tech*	*L041B*	*Rad Tech*	*57*		*7*			
10	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15**	**6**	**15**	**6**		
11	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**280**		**212**			
12	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3**	**3**	**3**	**3**		
13	**PRE-SERVICE**								
14	**Start: Following visit when decision for surgery or procedure made**								
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**3**	**3**	**3**	**3**		
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**3**		**3**			
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**3**		**3**		
18	Provide pre-service education/obtain consent								
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**3**		**3**			
20	Other Clinical Activity (please specify): Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	AngioTech	**6**		**6**			
21	**End: When patient enters office/facility for surgery/procedure**								
22	**SERVICE PERIOD**								
23	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
24	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		3			
25	Obtain vital signs	L037D	RN/LPN/MTA	5		3			
26	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5			
27	Prepare room, equipment, supplies (including imaging equipment)	L041B	Rad Tech	7		5			
28	Setup scope (non facility setting only)								
29	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		2			
30	Sedate/apply anesthesia	L051A	RN	2		2			
31	**Intra-service**								
32	Assist physician in performing procedure	L041A	AngioTech	60		60			
33	Assist physician in performing procedure (CS)	L051A	RN	60		60			
34	Assisting with flouroscopy/image acquisition (75%)	L041B	Rad Tech	45		45			
35	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA	15		15			
36	Image Post Processing	L041A	AngioTech	5		5			
37	**Post-Service**								
38	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60			
39	Clean room/equipment by physician staff	L041A	AngioTech	3		3			
40	Clean Scope								
41	Clean Surgical Instrument Package								
42	Complete diagnostic forms, lab & X-ray requisitions								
43	Review/read X-ray, lab, and pathology reports								
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3			
45	Discharge day management								
46	Other Clinical Activity (please specify)								

	A	B	C	D	E	F	G	H	I
1				37913		37197			
2	**Meeting Date: September 2011** **Specialty: SIR, ACR and SVS**	**CMS**	**Staff**	*Retrieval of intravascular vena cava filter* *Approved April 2011 Mtg*		*Transcatheter retrieval, percutaneous, of intravascular foreign body (eg fractured venous or arterial catheter), includes S&I and imaging guidance*			
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**		
47	**End: Patient leaves office**								
48	**POST-SERVICE Period**								
49	**Start: Patient leaves office/facility**								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**3**	**3**	**3**		
51	*Office visits: None*								
59	*Total Office Visit Time*			**0**	**0**				
60	Other Activity (please specify)								
61	**End: with last office visit before end of global period**								
62	**MEDICAL SUPPLIES**		**Unit**						
63	pack, minimum multi-specialty visit	SA048	pack	1		1			
64	pack, conscious sedation	SA044	pack	1		1			
65	gown, surgical, sterile	SB028	item	2		2			
66	gloves, sterile	SB024	pair	2		2			
67	mask, surgical, with face shield	SB034	item	4		4			
68	cap, surgical	SB001	item	4		4			
69	shoe covers, surgical	SB039	pair	4		4			
70	tray, shave prep	SA067	tray	1		1			
71	underpad 2ftx3ft (Chux)	SB044	item	1		1			
72	drape, sterile, femoral	SB009	item	1		1			
73	drape-towel, sterile 18inx26in	SB019	item	4		4			
74	Betadine	SJ041	ml	60		60			
75	applicator, sponge-tipped	SG009	item	4		4			
76	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10			
77	syringe 10-12 ml	SC051	item	4		4			
78	syringe, 20 cc	SC053	item	4		4			
79	sodium chloride 0.9% flush syringe	SH065	item	2		0			
80	closed flush system, angiography	SC010	item	1		1			
81	blade, surgical (Bard-Parker)	SF007	item	1		1			
82	steri-strip (6 strip uou)	SG074	item	1		1			
83	guidewire bowl w-lid, sterile	SD171	item	2		2			
84	gauze, sterile 4in x 4in	SG056	item	2		2			
85	dressing 3 X 4 wound care telfa	SG035	item	2		2			
86	drape, sterile, c-arm, fluoro	SB008	item	1		1			
87	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1			
88	cover-condom, transducer or ultrasound probe	SB005	item	1		1			
89	sheath-cover, sterile, 96in x 6in (transducer)	SB048	item	1		0			
90	tubing, pressure injection line (angiography)	SD211	item	1		1			
91	Sterile Radio-opaque ruler (le Maitre, documentation available)	SD249	item	1		1			
92	kit, guidewire introducer (Micro-Stick)	SA016	kit	1		1			
93	guidewire, (Bentson)	SD172	item	1		1			
94	catheter, angiographic, pig-tail	SC008	item	1		1			
95	vascular sheath	SD136	item	1		1			
96	introducer sheath, Ansel [45 cm 6 Fr Ansel	SD250	item	1		1			
97	kit, loop snare (Microvena)	SA020	item			1			
98	guidewire, Amplatz wire 260 cm	SD252	item			0			
99	guidewire, hydrophilic	SD089	item			1			
100	catheter, (Glide)	SD147	item			0			
101	Filter Retrieval Set	NEW	kit	1					
102	x-ray ID card (flashcard)	SK093	item	1		1			
103	film, x-ray 14inx17in	SK034	item	2		2			
104	x-ray envelope	SK091	item	1		1			
105	x-ray developer solution	SK089	oz	6		6			
106	x-ray fixer solution	SK092	oz	6		6			
107	**Equipment**								

	A	B	C	D	E	F	G	H	I
1				37913		37197			
2	**Meeting Date: September 2011** **Specialty: SIR, ACR and SVS**	**CMS**	**Staff**	*Retrieval of intravascular vena cava filter* *Approved April 2011 Mtg*		*Transcatheter retrieval, percutaneous, of intravascular foreign body (eg fractured venous or arterial catheter), includes S&I and imaging guidance*			
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**		
108	room, angiography	EL011		77		72			
109	Contrast media warmer	EQ088		62		0			
110	ultrasound unit, portable	EQ250		62		0			
111	film alternator	ER029		62		72			
112	printer, dye sublimation	ED031		5		5			
113	Stretcher	EF018		332					
114	table, instrument, mobile	EF027				302			
115	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		332		302			
116	IV infusion pump	EQ032		332		302			

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Accessory, Procedure	SD219	agent, embolic, 2 ml uou	unit	258
Accessory, Procedure	SD001	alloy, low temp fusible (Cerrobend, Indalloy)	lb	4.22
Accessory, Procedure	SD003	anoscope	item	0.923
Accessory, Procedure	SD253	atherectomy device (Spectronetics laser or Fox Hollow)	kit	4979.67
Accessory, Procedure	SD261	B5-2C Double Lumen Balloon 10 mm dia	item	126.75
Accessory, Procedure	SD140	bag system, 1000ml (for angiography waste fluids)	item	19
Accessory, Procedure	SD005	biopsy sponge (Histo-Prep)	item	0.054
Accessory, Procedure	SD006	bite block	item	1.5
Accessory, Procedure	SD007	bolus material (Superflab)	item	55
Accessory, Procedure	SD141	brush, protected airway specimen	item	13
Accessory, Procedure	SD008	brush, ureteral	item	47.5
Accessory, Procedure	SD142	bur, surgical, sterile (drill)	item	4.792
Accessory, Procedure	SD143	canister set, drainage, negative pressure (VAC)	item	29.355
Accessory, Procedure	SD009	canister, suction	item	3.908
Accessory, Procedure	SD010	canister, vacuum	item	5.456
Accessory, Procedure	SD144	canister, vacuum, pleural (w-drainage line)	item	31
Accessory, Procedure	SD011	cannula (radiofrequency denervation) (SMK-C10)	item	25
Accessory, Procedure	SD145	cannula, anterior chamber, 18-27g	item	2.688
Accessory, Procedure	SD012	catheter adapter	item	2.3
Accessory, Procedure	SD146	catheter percutaneous fastener (Percu-Stay)	item	12.745
Accessory, Procedure	SD013	catheter plug	item	1.435
Accessory, Procedure	SD014	catheter stylet	item	6.938
Accessory, Procedure	SD015	catheter tip adapter	item	0.998
Accessory, Procedure	SD147	catheter, (Glide)	item	62
Accessory, Procedure	SD148	catheter, (SIM2F1)	item	17
Accessory, Procedure	SD149	catheter, balloon inflation device	item	24.9
Accessory, Procedure	SD150	catheter, balloon ureteral (Dowd)	item	65
Accessory, Procedure	SD016	catheter, balloon, esophageal (pressure monitoring)	item	34.25
Accessory, Procedure	SD216	catheter, balloon, esophageal or rectal (graded distention test)	item	217
Accessory, Procedure	SD220	catheter, balloon, lacrimal	item	306
Accessory, Procedure	SD151	catheter, balloon, low profile PTA	item	431.5
Accessory, Procedure	SD152	catheter, balloon, PTA	item	243.5
Accessory, Procedure	SD017	catheter, balloon, rectal pressure	item	20.625
Accessory, Procedure	SD018	catheter, balloon, thermal ablation (Thermachoice)	tray	727
Accessory, Procedure	SD019	catheter, balloon, ureteral-GI (strictures)	item	166
Accessory, Procedure	SD153	catheter, curved	item	17.775
Accessory, Procedure	SD021	catheter, CVA, non-tunneled	item	106
Accessory, Procedure	SD022	catheter, CVA, peripheral, without port-pump	item	70.625
Accessory, Procedure	SD221	catheter, CVA, system, tunneled w-port, dual (LifeSite)	item	1750
Accessory, Procedure	SD020	catheter, CVA, tunneled, dual (Tesio)	item	355
Accessory, Procedure	SD023	catheter, enteroclysis	item	183.01
Accessory, Procedure	SD024	catheter, Foley	item	7.82
Accessory, Procedure	SD222	catheter, intradiscal (spineCATH)	item	1380
Accessory, Procedure	SD025	catheter, intrauterine insemination	item	7.1
Accessory, Procedure		catheter, Kumpe	item	
Accessory, Procedure	SD154	catheter, microcatheter (selective 3rd order)	item	337.88
Accessory, Procedure	SD026	catheter, Pezzar (mushroom)	item	13.95
Accessory, Procedure	SD027	catheter, pressure, urodynamic	item	13.733
Accessory, Procedure	SD028	catheter, Racz (Tun-L-Kath)	item	62.275
Accessory, Procedure	SD029	catheter, red rubber	item	0.973
Accessory, Procedure	SD155	catheter, RF endovenous occlusion	item	725
Accessory, Procedure	SD030	catheter, straight	item	1.7
Accessory, Procedure	SD031	catheter, suction	item	0.62
Accessory, Procedure	SD156	catheter, Swan Ganz	item	65
Accessory, Procedure	SD032	catheter, thrombectomy-Fogarty	item	101.75
Accessory, Procedure	SD157	catheter, ureteral, acorn tip	item	9.55
Accessory, Procedure	SD033	catheter, ureteral, open-ended	item	15
Accessory, Procedure	SD034	catheter, ureteral, Stamey open-tip	item	27
Accessory, Procedure	SD037	clip, tissue marker	item	75
Accessory, Procedure	SD158	conformer, sterile, acrylic	item	20
Accessory, Procedure	SD159	container, 2000ml, transfer pack	item	7.12
Accessory, Procedure	SD160	container, 600ml, transfer pack	item	3.3604
Accessory, Procedure	SD254	covered stent (VIABAHN, Gore)	item	3768
Accessory, Procedure	SD039	curette, suction, endometrial (Pipelle)	item	4.121
Accessory, Procedure	SD040	cytology, brush	item	0.2

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Accessory, Procedure	SD217	diaphragm fitting set	item	75
Accessory, Procedure	SD042	dilator, ductal, galactography	item	8
Accessory, Procedure	SD043	dilator, vessel, angiographic	item	6.5
Accessory, Procedure	SD161	drainage catheter, all purpose	item	88.43
Accessory, Procedure	SD162	drainage catheter, chest	item	88.89
Accessory, Procedure	SD163	drainage pouch, nephrostomy-biliary	item	13.25
Accessory, Procedure	SD044	ear tip, earphone	item	0.43
Accessory, Procedure	SD045	ear tip, immittance	item	0.165
Accessory, Procedure	SD046	ear tip, tympanometry probe	item	0.953
Accessory, Procedure	SD047	eartip insert with sound tube	item	0.423
Accessory, Procedure	SD048	electrode alligator clip, pair	pair	10.195
Accessory, Procedure	SD049	electrode needle, concentric EMG w-lead	item	8.693
Accessory, Procedure	SD050	electrode needle, injectable (Myoject)	item	20
Accessory, Procedure	SD051	electrode needle, monopolar EMG w-lead	item	3.03
Accessory, Procedure	SD223	electrode, array, nerve, preconfigured,	item	45
Accessory, Procedure	SD052	electrode, bar-style (single)	item	0.24
Accessory, Procedure	SD164	electrode, Bugbee	item	115
Accessory, Procedure	SD053	electrode, ECG (single)	item	0.09
Accessory, Procedure	SD165	electrode, EEG (single)	item	1.638
Accessory, Procedure	SD054	electrode, EEG, tin cup (12 pack uou)	item	18
Accessory, Procedure	SD166	electrode, EGG (single)	item	2.917
Accessory, Procedure	SD055	electrode, electrical stimulation	item	1.312
Accessory, Procedure	SD056	electrode, EMG sponge	item	6.467
Accessory, Procedure	SD057	electrode, external pelvic muscle	item	0.9
Accessory, Procedure	SD058	electrode, grid	item	475
Accessory, Procedure	SD059	electrode, ground	item	0.445
Accessory, Procedure	SD060	electrode, internal for pH	item	41.6
Accessory, Procedure	SD061	electrode, sphenoidal	item	15.833
Accessory, Procedure	SD062	electrode, surface	item	0.883
Accessory, Procedure	SD063	electrode, TENS-EMS, 2in x 2in (4 pack uou)	item	5.277
Accessory, Procedure	SD256	Embolic Protection Device Spider FX (EV3, documentation available)	item	1365
Accessory, Procedure	SD066	endoscopic biopsy forceps	item	50.6
Accessory, Procedure	SD067	endoscopic cytology brush	item	10.75
Accessory, Procedure	SD167	endoscopic deflecting brush	item	73.5
Accessory, Procedure	SD068	endoscopic polypectomy snare	item	19.7
Accessory, Procedure	SD070	endosheath	item	9.5
Accessory, Procedure	SD071	epistaxis balloon	item	43.063
Accessory, Procedure	SD072	eyelid weight implant, gold	item	217.5
Accessory, Procedure	SD074	filiform	item	9.19
Accessory, Procedure	SD075	filter, pulmonary function filter	item	1.44
Accessory, Procedure	SD169	forceps, Kelly	item	2.335
Accessory, Procedure	SD226	forceps, sterile, blunt tip, polystyrene	item	0.645
Accessory, Procedure	SD170	gas, 5% CO2 - balance air	liter	0.13
Accessory, Procedure	SD077	gas, air	cu ft	0.025
Accessory, Procedure	SD227	gas, argon	cu ft	0.25
Accessory, Procedure	SD228	gas, CO2, use w-automated insufflation, CT colonography	liter	1.826
Accessory, Procedure	SD079	gas, helium	cu ft	0.25
Accessory, Procedure	SD080	gas, intraocular C3F8 (ISPAN) (per dose)	item	3.323
Accessory, Procedure	SD082	gas, liquid nitrogen	ml	0.003
Accessory, Procedure	SD083	gas, nitrous oxide	liter	0.007
Accessory, Procedure	SD084	gas, oxygen	liter	0.003
Accessory, Procedure	SD085	gas, test mixture	liter	0.072
Accessory, Procedure	SD229	gastrostomy, stoma measuring device (Mic-Key)	item	10
Accessory, Procedure	SD086	grids	item	0.11
Accessory, Procedure	SD087	guide, needle, for localization	item	10.75
Accessory, Procedure	SD088	guidewire	item	9.998
Accessory, Procedure	SD171	guidewire bowl w-lid, sterile	item	3
Accessory, Procedure	SD252	guidewire, Amplatz wire 260 cm	item	47
Accessory, Procedure		guidewire, angle tip (Terumo), 180 cm	item	
Accessory, Procedure	SD172	guidewire, cerebral (Bentson)	item	14.5
Accessory, Procedure	SD089	guidewire, hydrophilic	item	35.5
Accessory, Procedure	SD173	guidewire, low profile (SpartaCore)	item	101.25
Accessory, Procedure	SD174	guidewire, steerable (Hi-Torque)	item	90
Accessory, Procedure	SD175	guidewire, steerable (Transcend)	item	180
Accessory, Procedure	SD090	guidewire, STIFF	item	23.9

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Accessory, Procedure	SD176	guidewire, torque	item	41
Accessory, Procedure	SD093	HEPA filter	item	4.962
Accessory, Procedure	SD247	human amniotic membrane allograft	item	595
Accessory, Procedure	SD248	human amniotic membrane allograft mounted on a non-absorbable self-retaining ring	item	895
Accessory, Procedure	SD177	hysteroscope, ablation device	item	1146
Accessory, Procedure	SD265	Imaging compatible electrodes	item	6
Accessory, Procedure	SD230	impedance catheter, infusion	item	95
Accessory, Procedure	SD262	Insuffalator - Boston Scientific	item	85
Accessory, Procedure	SD250	introducer sheath, Ansel [45 cm 6 Fr Ansel]	item	90
Accessory, Procedure	SD178	kit, bcr/abl DNA Probe	kit	42.65
Accessory, Procedure	SD179	lacrimal duct stent-tube set	item	74
Accessory, Procedure	SD094	Mammotome probe	item	200
Accessory, Procedure	SD180	manifold (for angiography)	item	6.682
Accessory, Procedure	SD096	markers, radiographic, multi-modality	item	2
Accessory, Procedure	SD182	mask, CPR (RespAide)	item	16.95
Accessory, Procedure	SD097	monofilament, sensory testing	item	0.23
Accessory, Procedure	SD099	mouthpiece, respiratory	item	0.217
Accessory, Procedure	SD100	nasal cannula	item	0.732
Accessory, Procedure	SD183	nasal tip, olive	item	0.34
Accessory, Procedure	SD184	nebulizer medication cup	item	0.14
Accessory, Procedure	SD101	nebulizer mouthpiece with tubing	item	1.654
Accessory, Procedure	SD231	needle, introducer (spineCATH)	item	69
Accessory, Procedure	SD102	noseclips	item	0.718
Accessory, Procedure	SD103	occluder, clip-on	item	1.442
Accessory, Procedure	SD104	oximetry sensor wrap	item	0.5
Accessory, Procedure	SD105	oxygen mask (1) and tubing (7ft)	item	0.963
Accessory, Procedure	SD106	pad, cardioversion R2 (2 pack)	item	29.75
Accessory, Procedure	SD107	peg, for prosthetic ocular implant	item	58.333
Accessory, Procedure	SD259	Peritoneal Dialysis Sterile Solution	item	6.37
Accessory, Procedure	SD185	plasma antibody adsorption column (Prosorba)	item	1150
Accessory, Procedure	SD186	plasma LDL adsorption column (Liposorber)	item	1300
Accessory, Procedure	SD187	plasma leukocyte filter	item	49.719
Accessory, Procedure	SD188	plasma separator (Liposorber)	item	100
Accessory, Procedure	SD189	plate, surgical, mini-compression, 4 hole	item	226
Accessory, Procedure	SD190	plate, surgical, mini-i, 16mm	item	147
Accessory, Procedure	SD191	plate, surgical, reconstruction, left, 5 x 16 hole	item	719
Accessory, Procedure	SD192	plate, surgical, reconstruction, template, 5 x 16 hole	item	50
Accessory, Procedure	SD193	plate, surgical, rigid comminuted fracture	item	389
Accessory, Procedure	SD194	plate, surgical, rigid comminuted fracture, template	item	29
Accessory, Procedure	SD232	probe, cryoablation (Visica ICE 30 or 40)	item	1589
Accessory, Procedure	SD233	probe, cryoablation, renal	item	1175
Accessory, Procedure	SD215	probe, endometrial cryoablation (Her Option)	item	1250
Accessory, Procedure	SD109	probe, radiofrequency, 3 array (StarBurstSDE)	item	1995
Accessory, Procedure	SD195	prosthesis, voice button (Blom-Singer)	item	48
Accessory, Procedure	SD255	Reentry device (Frontier, Outback, Pioneer)	item	
Accessory, Procedure	SD245	Renessa probe	item	1095
Accessory, Procedure	SD110	reservoir, drain (Jackson-Pratt)	item	22
Accessory, Procedure	SD111	respiratory monitoring belt	item	20
Accessory, Procedure	SD196	screw, surgical, auto-drive, 2.0mm x 4mm	item	37
Accessory, Procedure	SD197	screw, surgical, Carroll-Girard, 9cm x 3.75in	item	92
Accessory, Procedure	SD198	screw, surgical, lag, 2.4mm x 26mm	item	66
Accessory, Procedure	SD199	screw, surgical, locking, 2.4mm x 16mm	item	74
Accessory, Procedure	SD200	screw, surgical, self-tapping, 1.5-2.0mm	item	27
Accessory, Procedure	SD201	screw, surgical, standard, 2.4mm x 14mm	item	42
Accessory, Procedure	SD202	screw, surgical, standard, 2.7mm x 12mm	item	47
Accessory, Procedure	SD112	sensor, airflow cannula (adult)	item	3
Accessory, Procedure	SD113	sensor, EMG, vaginal-rectal	item	44.5
Accessory, Procedure	SD114	sensor, glucose monitoring (interstitial)	item	29.5
Accessory, Procedure	SD203	sensor, manometry	item	25
Accessory, Procedure	SD115	sensor, microvolt (Micro-V)	item	12
Accessory, Procedure	SD235	sensor, patch, bronchosopy (for kit, locatable guide) (patient)	item	1.1
Accessory, Procedure	SD204	sensor, pH capsule (Bravo)	item	225
Accessory, Procedure	SD116	sensors, bioimpendance (4 pack uou)	item	9.95
Accessory, Procedure	SD251	Sheath Shuttle (Cook)	item	
Accessory, Procedure	SD205	sheath, endoscope ultrasound balloon	item	154

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Accessory, Procedure	SD206	sheath, peel away	item	68.99
Accessory, Procedure	SD117	sigmoidoscope	item	2.459
Accessory, Procedure		snare, Nitinol (Amplatz)	item	
Accessory, Procedure	SD118	specula, vaginal	item	0.54
Accessory, Procedure	SD238	stent, GORE VIATORR TIPS Endoprosthesis	item	3450
Accessory, Procedure	SD266	stent, self expanding 2-5 mm XPERT (Abbott)	item	2495
Accessory, Procedure	SD239	stent, ureteral, w-guidewire, 3cm flexible tip	item	235
Accessory, Procedure	SD218	stent, ureteral, without guidewire	item	162
Accessory, Procedure	SD249	Sterile Radio-opaque ruler (le Maitre, documentation available)	item	46.95
Accessory, Procedure	SD240	strut, replacement, dynamic external fixation	item	1151
Accessory, Procedure	SD120	styrofoam block, high density (3in-12in-12in)	item	1.857
Accessory, Procedure	SD121	suction specimen trap, sterile	item	2.54
Accessory, Procedure	SD122	suction tip, Yankauer	item	1.116
Accessory, Procedure	SD207	suture device for vessel closure (Perclose A-T)	item	225
Accessory, Procedure	SD123	tourniquet, ankle, sterile	item	42.87
Accessory, Procedure	SD124	tourniquet, non-latex 1in x 18in	item	0.226
Accessory, Procedure	SD208	towel clamp, plastic	item	0.556
Accessory, Procedure	SD209	tracheostomy tube	item	20.934
Accessory, Procedure	SD125	transducer dome (pressure)	item	7.65
Accessory, Procedure	SD210	transducer, pressure monitoring (for angiography)	item	9.52
Accessory, Procedure	SC090	tube, gastrostomy	item	97
Accessory, Procedure	SD243	tube, jejunostomy	item	97.5
Accessory, Procedure	SD127	tube, suction NG (Salem sump)	item	3.218
Accessory, Procedure	SD128	tubing, for pump head	item	4.6
Accessory, Procedure	SD129	tubing, irrigation (cysto)	item	5.077
Accessory, Procedure	SD130	tubing, latex	foot	0.583
Accessory, Procedure	SD131	tubing, pressure	item	3.42
Accessory, Procedure	SD211	tubing, pressure injection line (angiography)	item	3.17
Accessory, Procedure	SD212	tubing, sterile, connecting (fluid administration)	item	1.95
Accessory, Procedure	SD213	tubing, sterile, non-vented (fluid administration)	item	0.949
Accessory, Procedure	SD214	tubing, suction, non-latex (2ft) with Frazier tip (1)	item	7.5566
Accessory, Procedure	SD132	tubing, suction, non-latex (6ft uou)	item	1.795
Accessory, Procedure	SD133	tubing, suction, non-latex (6ft) with Poole tip (1)	item	3.759
Accessory, Procedure	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	item	2.961
Accessory, Procedure	SD135	tubing, vacuum (for Mammotome device)	item	16
Accessory, Procedure	SD257	Tunneler	item	
Accessory, Procedure	SD246	urgent PC lead	item	65
Accessory, Procedure	SD136	vascular sheath	item	20.5
Accessory, Procedure	SD263	WatchPAT pneumo-opt slp probes	item	73.42
Accessory, Procedure	SD244	Water Barriers/Dust Traps (5/Pk)	item	4.94
Accessory, Procedure	SD138	wire, Nic-chrome	foot	0.45
Accessory, Procedure	SD260	Y-set connection tubing	item	151
Cutters, Closures, Cautery	SF001	arch bar	inch	0.66
Cutters, Closures, Cautery	SF003	blade, dermatome	item	17.4
Cutters, Closures, Cautery	SF004	blade, microtome	item	1.723
Cutters, Closures, Cautery	SF053	blade, sharp pointed surgical	item	0.73
Cutters, Closures, Cautery	SF005	blade, single edge	item	0.261
Cutters, Closures, Cautery	SF007	blade, surgical (Bard-Parker)	item	0.535
Cutters, Closures, Cautery	SF008	blade, surgical 64,65,67 (Beaver)	item	2.337
Cutters, Closures, Cautery	SF009	blade, surgical chisel 81-86 (Beaver)	item	3.301
Cutters, Closures, Cautery	SF010	blade, surgical hair clipper	item	5.036
Cutters, Closures, Cautery	SF011	blade, surgical, sterile, power saw	item	9.9
Cutters, Closures, Cautery	SF006	blade, surgical, super	item	2.083
Cutters, Closures, Cautery	SF044	blade, surgical, super-sharp	item	4.1667
Cutters, Closures, Cautery	SF045	blade, urethrotome	item	85.03
Cutters, Closures, Cautery	SF053	burs, dental	item	0.73
Cutters, Closures, Cautery	SF012	cautery, bipolar cord	item	4.733
Cutters, Closures, Cautery	SF013	cautery, bipolar, pencil-handpiece	item	26
Cutters, Closures, Cautery	SF014	cautery, electrode extender	item	7.383
Cutters, Closures, Cautery	SF015	cautery, monopolar, blade, extended shaft	item	3.063
Cutters, Closures, Cautery	SF016	cautery, monopolar, electrode tip	item	0.419
Cutters, Closures, Cautery	SF017	cautery, monopolar, electrode, loop	item	12.693
Cutters, Closures, Cautery	SF018	cautery, monopolar, electrode, needle	item	1.892
Cutters, Closures, Cautery	SF019	cautery, monopolar, electrode, spatula	item	40
Cutters, Closures, Cautery	SF020	cautery, monopolar, pencil-handpiece	item	4.638

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Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Cutters, Closures, Cautery	SF021	cautery, patient ground pad w-cord	item	3.07
Cutters, Closures, Cautery	SF022	comedone extractor	item	3
Cutters, Closures, Cautery	SF023	curette for ear cerumen	item	0.919
Cutters, Closures, Cautery	SF024	curette, dermal	item	1.373
Cutters, Closures, Cautery	SF025	dental elastics	item	0.008
Cutters, Closures, Cautery	SF026	endoscopic blade, surgical	item	40
Cutters, Closures, Cautery	SF027	endoscopic burr, surgical	item	40
Cutters, Closures, Cautery	SF028	laser tip (single use)	item	290
Cutters, Closures, Cautery	SF029	laser tip, bare (single use)	item	150
Cutters, Closures, Cautery	SF030	laser tip, diffuser fiber	item	850
Cutters, Closures, Cautery	SF031	loop, surgical (Surg-I-Loop)	item	1.275
Cutters, Closures, Cautery	SF032	rubber bands, sterile for ligation	item	0.145
Cutters, Closures, Cautery	SF033	scalpel with blade, surgical (#10-20)	item	0.694
Cutters, Closures, Cautery	SF047	scalpel, safety, surgical, with blade (#10-20)	item	2.143
Cutters, Closures, Cautery	SF034	stapler, surgical	item	7.509
Cutters, Closures, Cautery	SF035	suture, chromic, 2-0 to 5-0	item	4.291
Cutters, Closures, Cautery	SF048	suture, monocryl, 3-0 to 6-0, p, ps	item	9.8869
Cutters, Closures, Cautery	SF036	suture, nylon, 3-0 to 6-0, c	item	2.401
Cutters, Closures, Cautery	SF037	suture, nylon, 4-0 to 6-0, p, ps	item	6.714
Cutters, Closures, Cautery	SF049	suture, nylon, 8-0 to 9-0	item	15.32
Cutters, Closures, Cautery	SF050	suture, plain, gut, 2-0 to 6-0	item	4.2615
Cutters, Closures, Cautery	SF051	suture, polyester, 0 to 3-0 (Mersilene)	item	3.8953
Cutters, Closures, Cautery	SF038	suture, prolene, 3-0 to 7-0, p, ps, pc	item	8.76
Cutters, Closures, Cautery	SF039	suture, silk, 2-0 to 5-0, x, fs, c	item	2.936
Cutters, Closures, Cautery	SF040	suture, vicryl, 3-0 to 6-0, p, ps	item	7.852
Cutters, Closures, Cautery	SF052	suture, vicryl, 7-0	item	21.773
Cutters, Closures, Cautery	SF041	wire, contouring (radiation treatment)	lb	20
Cutters, Closures, Cautery	SF042	wire, Kirschner 7.5in	item	4.807
Cutters, Closures, Cautery	SF054	wire, orthodontic	item	
Cutters, Closures, Cautery	SF043	wire, surgical steel	foot	0.128
Gown, Drape	SB050	bolster covers, disposable	item	0.06
Gown, Drape	SB001	cap, surgical	item	0.209
Gown, Drape	SB029	cap-headcover, patient	item	0.061
Gown, Drape	SB049	condom, Diapulse, Asepticap	item	0.69
Gown, Drape	SB003	cover, probe (cryosurgery)	item	0.75
Gown, Drape	SB004	cover, thermometer probe	item	0.038
Gown, Drape	SB005	cover-condom, transducer or ultrasound probe	item	0.35
Gown, Drape	SB006	drape, non-sterile, sheet 40in x 60in	item	0.222
Gown, Drape	SB007	drape, sterile barrier 16in x 29in	item	0.494
Gown, Drape	SB008	drape, sterile, c-arm, fluoro	item	4.504
Gown, Drape	SB009	drape, sterile, femoral	item	15.949
Gown, Drape	SB010	drape, sterile, fenestrated 16in x 16in (eye)	item	3.435
Gown, Drape	SB011	drape, sterile, fenestrated 16in x 29in	item	0.557
Gown, Drape	SB012	drape, sterile, for Mayo stand	item	1.688
Gown, Drape	SB013	drape, sterile, hand-upper extremity	item	18.076
Gown, Drape	SB045	drape, sterile, incise, ophthalmic	item	4.9
Gown, Drape	SB046	drape, sterile, split-sheet	item	10.2425
Gown, Drape	SB014	drape, sterile, three-quarter sheet	item	3.83
Gown, Drape	SB015	drape, sterile, u-shape	item	11.397
Gown, Drape	SB016	drape-cover, sterile, OR light handle	item	1.059
Gown, Drape	SB017	drape-sleeve, sterile (4in x 8ft)	item	0.159
Gown, Drape	SB018	drape-sleeve, sterile, for handpiece	item	0.089
Gown, Drape	SB019	drape-towel, sterile 18in x 26in	item	0.282
Gown, Drape	SB020	drape-towel, sterile OR blue (2 pk uou)	item	1.657
Gown, Drape	SB021	gloves, cotton	pair	0.975
Gown, Drape	SB022	gloves, non-sterile	pair	0.084
Gown, Drape	SB023	gloves, non-sterile, nitrile	pair	0.188
Gown, Drape	SB024	gloves, sterile	pair	0.84
Gown, Drape	SB025	gloves, work-utility	pair	3.4
Gown, Drape	SB026	gown, patient	item	0.533
Gown, Drape	SB027	gown, staff, impervious	item	1.186
Gown, Drape	SB028	gown, surgical, sterile	item	4.671
Gown, Drape	SB030	lab coat, staff	item	4.522
Gown, Drape	SB031	lap sponge, sterile, 18inx18in (5 pack uou)	item	2.902
Gown, Drape	SB032	liner, baby scale	item	0.074

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Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Gown, Drape	SB033	mask, surgical	item	0.196
Gown, Drape	SB034	mask, surgical, with face shield	item	1.199
Gown, Drape	SB035	paper, chinrest	item	0.008
Gown, Drape	SB036	paper, exam table	foot	0.014
Gown, Drape	SB037	pillow case	item	0.307
Gown, Drape	SB038	safety glasses	item	2.902
Gown, Drape	SB048	sheath-cover, sterile, 96in x 6in (transducer)	item	9.583
Gown, Drape	SB039	shoe covers, surgical	pair	0.338
Gown, Drape	SB040	slippers, paper	pair	0.201
Gown, Drape	SB041	swimsuit, female for hydrotherapy	item	6.874
Gown, Drape	SB042	towel, non-sterile	item	0.391
Gown, Drape	SB043	towel, professional 13in x 18in	item	0.04
Gown, Drape	SB044	underpad 2ft x 3ft (Chux)	item	0.23
Gown, Drape		underwear, disposable	item	
Hypodermic, IV	SC065	adapter, luer lock	item	1.2485
Hypodermic, IV	SC066	adapter, spike (for syringe)	item	4.558
Hypodermic, IV	SC001	angiocatheter 14g-24g	item	1.505
Hypodermic, IV	SC002	angiocatheter set	item	11.272
Hypodermic, IV	SC003	arm board	item	0.598
Hypodermic, IV	SC004	blood collection bag	item	5.15
Hypodermic, IV	SC005	blood collection capillary tube	item	0.029
Hypodermic, IV	SC006	blood collection tube (Vacutainer)	item	0.201
Hypodermic, IV	SC067	blood collection tube holder	item	0.1625
Hypodermic, IV	SC068	blood collection tube needle	item	0.142
Hypodermic, IV	SC098	catheter, angiographic, Berman	item	
Hypodermic, IV	SC008	catheter, angiographic, pig-tail	item	19.75
Hypodermic, IV	SC070	catheter, hyperthermia, closed-end	item	20
Hypodermic, IV	SC071	catheter, hyperthermia, open-end	item	20
Hypodermic, IV	SC092	catheter, needle (for CPT 31626)	item	18
Hypodermic, IV	SC010	closed flush system, angiography	item	11.883
Hypodermic, IV	SC011	endoscopic sclerotherapy needle	item	21
Hypodermic, IV	SC088	fistula needle, dialysis, 17g	item	1.62
Hypodermic, IV	SC012	heparin lock	item	0.917
Hypodermic, IV	SC073	implant catheter, button-end, single leader	item	18.5
Hypodermic, IV	SC013	infusion pump cassette-reservoir	item	12.963
Hypodermic, IV	SC014	Interlink adaptor	item	1.725
Hypodermic, IV	SC015	Interlink vial access	item	2.04
Hypodermic, IV	SC018	iv infusion set	item	1.112
Hypodermic, IV	SC093	IV infusion set, Sof-set (Minimed)	item	11.5
Hypodermic, IV	SC074	iv pressure infusor bag	item	18.46
Hypodermic, IV	SC019	iv tubing (extension)	foot	0.53
Hypodermic, IV	SC021	lancet	item	0.038
Hypodermic, IV	SC022	Mammotome probe guide	item	7
Hypodermic, IV	SC023	multi-tine device	item	0.233
Hypodermic, IV	SC025	needle, 14-20g, biopsy	item	8.375
Hypodermic, IV	SC026	needle, 15-16g	item	0.232
Hypodermic, IV	SC027	needle, 18-19g, filter	item	0.37
Hypodermic, IV	SC028	needle, 18-26g 1.5-3.5in, spinal	item	3.314
Hypodermic, IV	SC029	needle, 18-27g	item	0.089
Hypodermic, IV	SC030	needle, 19-25g, butterfly	item	0.798
Hypodermic, IV	SC031	needle, 30g	item	0.344
Hypodermic, IV	SC075	needle, acupuncture	item	0.094
Hypodermic, IV	SC041	needle, arterial (Seldinger)	item	5.175
Hypodermic, IV	SC076	needle, arterial, percutaneous	item	3.15
Hypodermic, IV	SC032	needle, biopsy for breast-prostate core sample	item	28.42
Hypodermic, IV	SC033	needle, biopsy, spring-loaded	item	19
Hypodermic, IV	SC034	needle, blunt tip	item	0.33
Hypodermic, IV	SC077	needle, bone biopsy	item	65
Hypodermic, IV	SC035	needle, Chiba	item	8.477
Hypodermic, IV	SC037	needle, dental	item	0.086
Hypodermic, IV	SC038	needle, epidural (RK)	item	10
Hypodermic, IV	SC078	needle, flexi, hyperthermia	item	12
Hypodermic, IV	SC039	needle, Huber point	item	3.328
Hypodermic, IV	SC040	needle, Kopan	item	18.75
Hypodermic, IV	SC079	needle, micropigmentation (tattoo)	item	12

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Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Hypodermic, IV	SC080	needle, OSHA compliant (SafetyGlide)	item	0.454
Hypodermic, IV	SC081	needle, retrobulbar (Atkinson)	item	1.825
Hypodermic, IV	SC042	needle, spine, Sprotte	item	8.6
Hypodermic, IV	SC043	needle, transbronchial, cytology (Wang)	item	58.05
Hypodermic, IV	SC089	needle, Vacutainer	item	0.32
Hypodermic, IV	SC044	needle, variceal injection	item	36
Hypodermic, IV	SC045	needle-wire for localization	item	15
Hypodermic, IV	SC097	Peritoneal Dialysis Catheter	item	487
Hypodermic, IV	SC046	punch, biopsy	item	1.888
Hypodermic, IV	SC096	Quick Cross Catheter (Sprectranetics, documentation available)	item	197
Hypodermic, IV	SC047	sialography infusion unit	item	24
Hypodermic, IV	SC048	spinal manometer	item	26.325
Hypodermic, IV	SC049	stop cock, 3-way	item	1.175
Hypodermic, IV	SC050	stop cock, 4-way	item	1.621
Hypodermic, IV	SC051	syringe 10-12ml	item	0.184
Hypodermic, IV	SC082	syringe 12ml, coronary control	item	7
Hypodermic, IV	SC052	syringe 1ml	item	0.14
Hypodermic, IV	SC053	syringe 20ml	item	0.558
Hypodermic, IV	SC054	syringe 30 ml	item	0.63
Hypodermic, IV	SC055	syringe 3ml	item	0.096
Hypodermic, IV	SC056	syringe 50-60ml	item	0.881
Hypodermic, IV	SC057	syringe 5-6ml	item	0.15
Hypodermic, IV	SC095	syringe filter	item	2.04
Hypodermic, IV	SC058	syringe w-needle, OSHA compliant (SafetyGlide)	item	0.435
Hypodermic, IV	SC059	syringe, 25ml (MRI power injector)	item	5.445
Hypodermic, IV	SC092	syringe, impression	item	18
Hypodermic, IV	SC060	syringe, pressure (radiology)	item	8.179
Hypodermic, IV	SC062	syringe, Toomey	item	2.726
Hypodermic, IV	SC063	syringe-needle 10ml 26g	item	0.273
Hypodermic, IV	SC064	syringe-needle 3ml 22-26g	item	0.16
Hypodermic, IV	SC083	tubing set (Liposorber)	item	50
Hypodermic, IV	SC084	tubing set, blood warmer	item	7.3958
Hypodermic, IV	SC085	tubing set, plasma exchange	item	173.3333
Hypodermic, IV	SC086	tubing set, plasma transfer	item	1.68
Hypodermic, IV	SC087	tubing set, Y-type blood recipient	item	5.75
Hypodermic, IV	SC091	Vacutainer	item	5.9
Infection Control	SM001	atomizer tip shield (RhinoGuard)	item	0.56
Infection Control	SM002	autoclave bag	item	0.07
Infection Control	SM003	autoclave tape	yd	0.092
Infection Control	SM004	biohazard bag	item	
Infection Control	SM005	biohazard glass disposal box (per disposed slide)	item	0.138
Infection Control	SM007	biohazard pipette container	item	1.886
Infection Control	SM008	biohazard specimen transport bag	item	0.035
Infection Control	SM009	cleaner, x-ray cassette-screen	oz	0.891
Infection Control	SM010	cleaning brush, endoscope	item	4.992
Infection Control	SM011	cleaning brush, instruments	item	1.95
Infection Control	SM012	disinfectant spray (Transeptic)	ml	0.028
Infection Control	SM012	disinfectant spray (Transeptic) ml	ml	0.028
Infection Control	SM013	disinfectant, surface (Envirocide, Sanizide)	oz	0.163
Infection Control	SM014	endoscope anti-fog solution	ml	1.067
Infection Control	SM015	enzymatic detergent	oz	0.229
Infection Control	SM016	eye shield, splash protection	item	1.471
Infection Control	SM028	filter, mouthpiece (NIOX)	item	4.6
Infection Control	SM017	formaldehyde spill control	ml	0.005
Infection Control	SM018	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	oz	0.165
Infection Control	SM019	glutaraldehyde test strips (Cidex, Metrex)	item	1.012
Infection Control	SM020	lotion, antibacterial	oz	0.3
Infection Control	SM021	sanitizing cloth-wipe (patient)	item	0.037
Infection Control	SM022	sanitizing cloth-wipe (surface, instruments, equipment)	item	0.046
Infection Control	SM023	scrub brush (impregnated)	item	0.599
Infection Control	SM024	soap, liquid, antibacterial	oz	0.203
Infection Control	SM025	specula tips, otoscope	item	0.03
Infection Control	SM026	whirlpool antiseptic (80gm pack) (Chlorazene)	item	1.689
Infection Control	SM027	wipes, lens cleaning (per wipe) (Kimwipe)	item	0.013
Kit, Pack, Tray	SA071	kit, AccuStick II Introducer System with RO Marker	kit	82.62

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Kit, Pack, Tray	SA001	kit, activity-crafts	kit	2.25
Kit, Pack, Tray	SA002	kit, ambulatory Holter	kit	4.449
Kit, Pack, Tray	SA072	kit, apheresis treatment	kit	140
Kit, Pack, Tray	SA003	kit, arterial blood gas (ABG)	kit	1.875
Kit, Pack, Tray	SA073	kit, barium enema	kit	9.466
Kit, Pack, Tray	SA004	kit, barium with insufflator	kit	32.985
Kit, Pack, Tray	SA089	kit, boston original system	kit	4.5
Kit, Pack, Tray	SA005	kit, capsule endoscopy w-application supplies (M2A)	kit	450
Kit, Pack, Tray	SA094	kit, capsule, ESO, endoscopy w-application supplies (ESO)	kit	450
Kit, Pack, Tray	SA006	kit, catheter, suprapubic	kit	34.75
Kit, Pack, Tray	SA007	kit, cooking activity ingredients (mac-cheese)	kit	1.11
Kit, Pack, Tray	SA009	kit, CVA catheter, non-tunneled	kit	68
Kit, Pack, Tray	SA011	kit, CVA catheter, tunneled, with subcut port	kit	495
Kit, Pack, Tray	SA010	kit, CVA catheter, tunneled, without port-pump	kit	308
Kit, Pack, Tray	SA012	kit, CVA device repair	kit	94.23
Kit, Pack, Tray	SA014	kit, electrode, iontophoresis	kit	11.992
Kit, Pack, Tray	SA074	kit, endovascular laser treatment	kit	519
Kit, Pack, Tray	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	487.5
Kit, Pack, Tray	SA095	kit, gastrostomy, low profile device (Mic-Key)	item	210
Kit, Pack, Tray	SA092	kit, gene, MLL fusion	kit	1395
Kit, Pack, Tray	SA016	kit, guidewire introducer (Micro-Stick)	kit	23
Kit, Pack, Tray	SA075	kit, hysteroscopic tubal implant for sterilization	kit	1245
Kit, Pack, Tray	SA017	kit, interactive materials (crayons,chalk,paper)	kit	0.04
Kit, Pack, Tray	SA018	kit, interactive materials for behavioral assessment	kit	0.04
Kit, Pack, Tray	SA096	kit, introducer, radiofrequency, XIi-enhanced RF probe	kit	99
Kit, Pack, Tray	SA019	kit, iv starter	kit	1.368
Kit, Pack, Tray	SA097	kit, locatable guide, ext. working channel, w-b-scope adapter	kit	995
Kit, Pack, Tray	SA020	kit, loop snare (Microvena)	kit	275
Kit, Pack, Tray	SA090	kit, moulage (implantech)	kit	75
Kit, Pack, Tray	SA098	kit, nebulizer, w-tubing and aerosole mask (Hope)	kit	19.64
Kit, Pack, Tray	SA021	kit, needle-free injection system	kit	9.492
Kit, Pack, Tray	SA022	kit, percutaneous neuro test stimulation	kit	305
Kit, Pack, Tray	SA023	kit, phenol applicator	kit	15.152
Kit, Pack, Tray	SA024	kit, photopheresis procedure	kit	858
Kit, Pack, Tray	SA025	kit, PICC with subcut port	kit	586
Kit, Pack, Tray	SA077	kit, pleural catheter insertion	kit	329
Kit, Pack, Tray	SA093	kit, priming, random	kit	463
Kit, Pack, Tray	SA099	Kit, probe, cryoablation, prostate (Galil-Endocare)	kit	4700
Kit, Pack, Tray	SA100	kit, probe, radiofrequency, XIi-enhanced RF probe	kit	2695
Kit, Pack, Tray	SA026	kit, radiofrequency introducer	kit	50
Kit, Pack, Tray	SA076	kit, refill for implantable medication pump	item	28
Kit, Pack, Tray	SA027	kit, scissors and clamp	kit	0.62
Kit, Pack, Tray	SA028	kit, sensory integration	kit	2.08
Kit, Pack, Tray	SA029	kit, sharp debridement	kit	4.114
Kit, Pack, Tray	SA107	kit, sinus surgery, balloon (maxillary)	kit	1295
Kit, Pack, Tray	SA106	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	kit	2599.86
Kit, Pack, Tray	SA078	kit, slit catheter (for compartment pressure monitor)	kit	73.75
Kit, Pack, Tray	SA030	kit, staple removal	kit	1.203
Kit, Pack, Tray	SA101	kit, stent, urethral, prostatic, insertion tool and surveyor	kit	575
Kit, Pack, Tray	SA031	kit, suture removal	kit	1.054
Kit, Pack, Tray	SA032	kit, tangible reinforcement-reward for children	kit	1.5
Kit, Pack, Tray	SA033	kit, therapeutic toys-games	kit	0.2
Kit, Pack, Tray	SA034	kit, therapeutic toys-games (50% of the time)	kit	0.1
Kit, Pack, Tray	SA108	kit, tissue expansion	item	8.313
Kit, Pack, Tray	SA035	kit, tracheostomy care	kit	2.085
Kit, Pack, Tray	SA036	kit, transurethral microwave thermotherapy	kit	1149
Kit, Pack, Tray	SA037	kit, transurethral needle ablation (TUNA)	kit	1050
Kit, Pack, Tray	SA038	kit, transurethral water-induced thermotherapy	kit	650
Kit, Pack, Tray	SA102	kit, tubing, use w-automated insufflation, CT colonography	kit	20.83
Kit, Pack, Tray	SA039	kit, vertebroplasty (LP2, CDO)	kit	696
Kit, Pack, Tray	SA040	kit, woodworking	kit	12.99
Kit, Pack, Tray	SA041	pack, basic injection	pack	11.67
Kit, Pack, Tray	SA042	pack, cleaning and disinfecting, endoscope	pack	15.52
Kit, Pack, Tray	SA043	pack, cleaning, surgical instruments	pack	5.339
Kit, Pack, Tray	SA044	pack, conscious sedation	pack	17.311

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Kit, Pack, Tray	SA045	pack, drapes, cystoscopy	pack	9.864
Kit, Pack, Tray	SA046	pack, drapes, laparotomy (chest-abdomen)	pack	26.118
Kit, Pack, Tray	SA080	pack, drapes, ortho, large	pack	40.646
Kit, Pack, Tray	SA081	pack, drapes, ortho, small	pack	1.128
Kit, Pack, Tray	SA047	pack, EM visit	pack	2.984
Kit, Pack, Tray	SA048	pack, minimum multi-sof-setspecialty visit	pack	1.143
Kit, Pack, Tray	SA048	pack, minimum multi-specialty visit	pack	1.143
Kit, Pack, Tray	SA049	pack, ocular photodynamic therapy	pack	20.675
Kit, Pack, Tray	SA050	pack, ophthalmology visit (no dilation)	pack	1.185
Kit, Pack, Tray	SA082	pack, ophthalmology visit (w-dilation)	pack	1.997
Kit, Pack, Tray	SA051	pack, pelvic exam	pack	1.172
Kit, Pack, Tray	SA052	pack, post-op incision care (staple)	pack	5.056
Kit, Pack, Tray	SA053	pack, post-op incision care (suture & staple)	pack	6.11
Kit, Pack, Tray	SA054	pack, post-op incision care (suture)	kit	4.907
Kit, Pack, Tray	SA054	pack, post-op incision care (suture)	pack	4.907
Kit, Pack, Tray	SA055	pack, post-op incision care, craniotomy	pack	7.3
Kit, Pack, Tray	SA056	pack, post-op incision care, neurosurgical	pack	6.203
Kit, Pack, Tray	SA083	pack, protective, ortho, large	pack	9.182
Kit, Pack, Tray	SA084	pack, protective, ortho, small	pack	4.441
Kit, Pack, Tray	SA057	pack, shower protection for insulin pump	pack	0.616
Kit, Pack, Tray	SA058	pack, urology cystoscopy visit	pack	24.685
Kit, Pack, Tray	SA103	stent, vascular, deployment system, Cordis SMART	item	1645
Kit, Pack, Tray	SA103	stent, vascular, deployment system, Cordis SMART	kit	1645
Kit, Pack, Tray	SA104	ThinPrep UroCyte Urine Collection Kit	kit	7
Kit, Pack, Tray	SA059	tray, amniocentesis	tray	19.423
Kit, Pack, Tray	SA060	tray, arthrogram	tray	18.83
Kit, Pack, Tray	SA061	tray, biopsy procedure	tray	14.65
Kit, Pack, Tray	SA062	tray, bone marrow biopsy-aspiration	tray	24.271
Kit, Pack, Tray	SA063	tray, catheter insertion (w-o catheter)	tray	4.136
Kit, Pack, Tray	SA085	tray, central line dressing change	tray	2.43
Kit, Pack, Tray	SA086	tray, circumcision	tray	25.1725
Kit, Pack, Tray	SA064	tray, epidural	tray	23.829
Kit, Pack, Tray	SA065	tray, lumbar puncture	tray	18.552
Kit, Pack, Tray	SA066	tray, myelogram	tray	23.869
Kit, Pack, Tray	SA087	tray, RTS applicator (MammoSite)	item	2550
Kit, Pack, Tray	SA091	tray, scoop, fast track system	tray	750
Kit, Pack, Tray	SA067	tray, shave prep	tray	1.812
Kit, Pack, Tray	SA068	tray, spinal anesthesia	tray	21.832
Kit, Pack, Tray	SA088	tray, surgical skin prep, sterile	tray	6.7647
Kit, Pack, Tray	SA069	tray, suturing	tray	8.993
Kit, Pack, Tray	SA070	tray, thoracentesis	tray	37.382
Kit, Pack, Tray	SA105	UroVysion test kit	item	176.8
Lab	SL178	0.2N HCL	ml	0.013
Lab	SL254	0.45 µm pore filtration unit	item	10.138
Lab	SL179	1.0N NaOH	ml	0.489
Lab	SL255	12-well slides	item	0.84
Lab	SL001	acetone	ml	0.014
Lab	SL152	acrylic tray-base material	oz	1.7746
Lab	SL205	acylic, dental	gm	
Lab	SL153	adhesive, conductive (silver, liquid)	gm	3
Lab	SL002	AEC buffer	ml	0.653
Lab	SL003	AEC chromogen	ml	18.667
Lab	SL206	aerosol barrier tips, beveled	item	0.047
Lab	SL207	air, filtered, compressed	item	8.79
Lab	SL154	alcohol ethyl 100%	ml	0.028
Lab	SL004	alcohol reagent solvent	ml	0.011
Lab	SL005	alcohol, acid	ml	0.004
Lab	SL006	alcohol, ethyl, denatured	ml	0.036
Lab	SL208	alloy framework, laboratory processing	item	
Lab	SL009	antibody C3	ml	52.05
Lab	SL010	antibody FITC monoclonal conjugate (each test)	item	3.544
Lab	SL011	antibody HMB-45	ml	26.6
Lab	SL012	antibody IgA FITC	ml	71.4
Lab	SL013	antibody IgG FITC	ml	62.2
Lab	SL014	antibody IgG1 FITC anti-human (each test)	item	2.3

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Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Lab	SL015	antibody IgM FITC	ml	62.2
Lab	SL186	antibody, flow cytometry (each test)	item	8.5
Lab	SL155	applicator, wood, 6.5in	item	0.0079
Lab	SL209	array kit, GenoSensor	item	2121
Lab	SL017	background block	ml	0.245
Lab	SL187	balance salt solution (BSS), sterile, 15cc	ml	
Lab	SL018	beaker, 250 ml	item	0.854
Lab	SL019	biotinylated link (mouse, rabbit)	ml	1.995
Lab	SL020	bleach	ml	0.001
Lab	SL259	Bleach cleaning wipe	item	1.04
Lab	SL210	buffer, gel-loading, 6X (bromophenol+xylenne+cyanol)	ml	6
Lab	SL246	buffer, lysis	ml	0.46
Lab	SL211	caffeine	gm	0.214
Lab	SL021	calibration beads (each test)	item	9.62
Lab	SL247	caps, Capsure Macro LCM	ml	4.54
Lab	SL023	carbon rod	item	3
Lab	SL024	centrifuge tube	item	0.054
Lab	SL212	CHCT buffer (NaCl, NaHCO3, KCl, KH2PO4, MgSO4,CaCl12-2H20)	liter	1.24
Lab	SL025	chloroform	ml	0.027
Lab	SL026	clearing agent (Histo-clear)	ml	0.008
Lab	SL027	color coded cap and vial (for antigen)	item	0.564
Lab	SL213	column, microspin, S-200 HR	item	3.14
Lab		container, storage, plastic, 11 oz	item	
Lab	SL258	Control slides	kit	228
Lab	SL028	copper (ref std soln)	ml	0.104
Lab	SL029	counterstain (neutral red soln)	ml	0.656
Lab	SL214	cover slip, covalent binding	item	5.75
Lab	SL030	cover slip, glass	item	0.079
Lab	SL031	cover slip, liquid (M-1)	ml	0.039
Lab	SL032	culture media	ml	0.013
Lab	SL033	culture swab system (Culturette)	item	0.865
Lab	SL034	cup, biopsy-specimen 86oz	item	1.643
Lab	SL035	cup, biopsy-specimen non-sterile 4oz	item	0.087
Lab	SL036	cup, biopsy-specimen sterile 4oz	item	0.173
Lab	SL037	cup, medicine (1oz size)	item	0.009
Lab	SL156	cup, sterile, 12-16 oz	item	0.76
Lab	SL157	cup, sterile, 8 oz	item	0.542
Lab	SL038	cup-container, sterile, graduated 1000ml	item	1.14
Lab	SL215	Cyanine 5 dCTP, 1mM	ul	11.44
Lab	SL039	cytology, lysing soln (CytoLyt)	ml	0.034
Lab	SL040	cytology, preservative and vial (Preserv-cyt)	item	0.8
Lab	SL041	cytology, specimen filter (Transcyt)	item	4.15
Lab	SL042	cytology, transport prefilled container	item	0.612
Lab	SL043	cytology, vacuum grease	oz	2.83
Lab	SL044	DDSA	gm	0.042
Lab	SL045	decalcifier solution	ml	0.017
Lab	SL046	dental impression tray	item	0.446
Lab	SL047	dental stone powder	lb	1.598
Lab	SL048	desiccant-absorber	item	0.158
Lab	SL158	diamond knife cleaning rod	item	1
Lab	SL050	DMP 30	gm	0.236
Lab	SL051	DNA 0.05N HCl rinse reagent	ml	0.004
Lab	SL052	DNA 0.1N HCl staining soln	ml	0.004
Lab	SL053	DNA 5N HCl	ml	0.004
Lab	SL054	DNA calibration slides	item	1.25
Lab	SL216	DNA ladder, 1-Kb	item	77
Lab	SL217	DNA ladder, 50-bp	item	102
Lab	SL055	DNA stain kit (per test)	item	150
Lab	SL218	DNA, Versagene, blood kit	item	4.141
Lab	SL056	dry ice	lb	0.96
Lab	SL219	dye, flourescent, Hoechst 33258	ug/ml	0.65
Lab	SL188	EM fixative, karnovsky's	ml	0.086
Lab	SL057	embedding capsules	item	0.045
Lab	SL058	embedding cassette	item	0.159
Lab	SL059	embedding epoxy (NMA)	ml	0.036

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Lab	SL060	embedding mold	item	0.149
Lab	SL061	embedding paraffin	kg	5.363
Lab	SL062	enzyme reagent (DAB)	ml	0.552
Lab	SL063	eosin y	gm	0.801
Lab	SL189	ethanol, 100%	ml	0.0033
Lab	SL220	ethanol, 200%	ul	0.046
Lab	SL190	ethanol, 70%	ml	0.0033
Lab	SL191	ethanol, 85%	ml	0.0033
Lab	SL248	ethanol, 95%	ml	0.0033
Lab	SL064	filter paper, qualitative, <15.0cm	item	0.125
Lab	SL065	filter paper, qualitative, 18.5cm	item	0.341
Lab	SL066	filter, nylon mesh (55mm)	item	0.568
Lab	SL261	FISH pre-treatment kit	kit	549
Lab	SL067	fixative (Bouin's fluid)	ml	0.034
Lab	SL068	fixative (for tissue specimen)	ml	0.013
Lab	SL069	fixative (Michel's)	ml	0.151
Lab	SL070	fixative processing (buffered formalin)	ml	0.009
Lab	SL071	fixative spray	ml	0.047
Lab	SL221	flask, filter, 0.2 micron	item	14.396
Lab	SL072	formalin	ml	0.009
Lab	SL192	formamide	ml	0.22
Lab	SL260	Fresh Fixative (3:1, methanol: acetic acid)	item	0.0876
Lab	SL222	gas, halothane	ml	0.104
Lab	SL223	gas, mixture, tank G, 5% CO2 and 95% O2	item	20
Lab	SL224	gas, mixture, tank H	item	20
Lab	SL225	gas, nitogen, ultra-high purity (compressed), grade 5.0	item	189.87
Lab	SL159	gas, nitrogen	cu ft	2.708
Lab	SL226	gel, mini, 1% Agarose (in 1X TAE buffer)	item	5.5
Lab	SL227	gel, mini, 2% Agarose (in 1X TAE buffer)	item	20
Lab	SL160	glass knife boat	item	0.2
Lab	SL074	glass strip (each)	item	3.167
Lab	SL075	glutaraldehyde 25%	ml	0.148
Lab	SL249	glycerol, 3%	ml	0.001
Lab	SL193	glycolic acid, 20-50%	ml	0.156
Lab	SL228	Greenstick compound	item	
Lab	SL161	grid storage box (holds 50 grids)	item	3.75
Lab	SL229	HCl, 1% hydrochloric acid	cc	0.159
Lab	SL077	hematoxylin reagent	ml	0.32
Lab	SL194	Hemo-De	ml	0.0083
Lab	SL078	histology freezing spray (Freeze-It)	oz	1.443
Lab	SL257	Humidity cards	item	0.3406
Lab	SL079	hydrochloric acid 0.1%, std soln	ml	0.017
Lab	SL080	immersion oil	ml	0.079
Lab	SL081	impression material, alginate (dental)	lb	7.5
Lab	SL082	impression material, dental putty (per bite block)	item	2.138
Lab	SL230	impression material, final	ml	
Lab	SL083	indocyanine green (25ml uou)	item	76.875
Lab	SL084	Isoton II diluent	ml	0.002
Lab	SL195	kit, FISH paraffin pretreatment	kit	20.85
Lab	SL196	kit, HER-2/neu DNA Probe	kit	105
Lab	SL231	kit, stain, H&E	kit	98.02
Lab	SL232	KOH	gm	0.084
Lab	SL197	label for blood tube	item	0.0035
Lab	SL085	label for microscope slides	item	0.026
Lab	SL198	label, vial	item	0.0027
Lab	SL162	lead citrate	gm	0.51
Lab	SL087	lens paper	item	0.027
Lab	SL088	lint-free cloth	item	0.183
Lab	SL199	lithium carbonate, saturated	ml	0.01
Lab	SL089	lysing reagent (FACS)	ml	4.485
Lab	SL090	methanol, absolute, 99.8% min.	ml	0.025
Lab	SL091	methylbutane (Isopentane)	ml	0.021
Lab	SL250	methylene blue stain	ml	0.178
Lab	SL093	mold release agent, liquid	ml	0.062
Lab	SL094	mold release agent, silicone spray	oz	0.54

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Lab	SL163	mount, carbon spectro-pure (for SEM)	item	0.5
Lab	SL182	mounting media (DAPI II counterstain)	ml	67
Lab	SL095	mounting media (Histomount)	ml	0.035
Lab	SL096	negative control (anti-albumin)	ml	41.75
Lab	SL253	Non-Gyn Filter unit	item	4.44
Lab	SL097	OCT Tissue-Tek	ml	0.06
Lab	SL098	osmium tetroxide	gm	35
Lab	SL164	osmometer sample tip and cleaner	item	0.534
Lab	SL165	osmometer std, 50 mOsm-kg, 2ml amp	ml	17
Lab	SL166	osmometer std, 850 mOsm-kg, 2ml amp	ml	17
Lab	SL167	paper, weighing (glassine)	item	0.021
Lab	SL099	paraformaldehyde	gm	0.073
Lab	SL101	Pepsin	gm	34.6
Lab	SL102	peroxide block	ml	0.049
Lab	SL103	petri dish	item	0.132
Lab	SL104	phosphate buffer, dibasic	gm	0.048
Lab	SL105	phosphate buffer, monobasic	gm	0.038
Lab	SL180	phosphate buffered saline (PBS)	ml	0.025
Lab	SL106	phosphate buffered saline packet (Zeus)	item	2.09
Lab	SL107	phosphate buffered saline solution	ml	0.041
Lab	SL108	pipette	item	0.033
Lab	SL168	pipette bulb	item	0.2708
Lab	SL110	pipette tip (blue-yellow)	item	0.048
Lab	SL233	pipette tips, aerosol resistant	item	0.086
Lab	SL181	pipette tips, sterile	item	0.0627
Lab	SL234	pipette tips, sterile, DNase free	item	0.055
Lab	SL235	pipette tips, wide orifice, 250ul	item	0.06
Lab	SL169	pipette, 9inch	item	0.0537
Lab	SL109	pipette, transfer 23ml	item	0.338
Lab	SL111	Poly Bed 812	gm	0.061
Lab	SL112	positive control slide	item	11.8
Lab	SL115	propidium iodide	ml	5.07
Lab	SL116	propylene oxide	ml	0.031
Lab	SL117	protein blocking agent	ml	0.894
Lab	SL236	reline material, Trusoft	gm	
Lab	SL118	R-Nase One	unit	0.079
Lab	SL251	Rnase-free water	ml	0.85
Lab	SL119	sealant spray	oz	
Lab	SL237	silicone	gm	
Lab	SL120	slide container (for 20 microscope slides)	item	6.652
Lab	SL121	slide specimen mailer (1-5 microscope slides)	item	0.46
Lab	SL238	slide, glass, (plain blank slide)	item	0.284
Lab	SL122	slide, microscope	item	0.055
Lab	SL252	slide, microscope, sterile	item	1
Lab	SL184	slide, negative control, Her-2	item	29.4
Lab	SL183	slide, organosilane coated	item	0.3733
Lab	SL185	slide, positive control, Her-2	item	29.4
Lab	SL170	sodium acetate	gm	0.064
Lab	SL171	sodium barbital	gm	0.3151
Lab	SL200	sodium bicarbonate spray, 8 oz	item	9.5
Lab	SL125	sodium cacodylate	gm	0.48
Lab	SL126	sodium chloride, 99.0% min.	gm	0.039
Lab	SL127	sodium citrate	gm	0.018
Lab	SL128	sodium hydroxide	gm	0.064
Lab	SL130	spatula (pathology)	item	0.716
Lab	SL172	specimen block storage box	item	0.625
Lab	SL131	stain kit, copper (per slide)	item	19.9
Lab	SL132	stain kit, oil red O (per slide)	item	4.025
Lab	SL133	stain kit, PAS (per slide)	item	16.1
Lab	SL201	stain, eosin	ml	0.0436
Lab	SL134	stain, frozen section, H&E (1ml per slide)	ml	0.567
Lab	SL135	stain, hematoxylin	ml	0.044
Lab	SL136	stain, Lugol's	ml	0.695
Lab	SL239	stain, nucleic acid gel (10X3 in DMSO (Ethidium bromide)	ul	0.198
Lab	SL137	stain, PAP EA-50	ml	0.035

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Lab	SL138	stain, PAP toluidine blue O	ml	0.089
Lab	SL139	stain, quick differential (5ml per slide)	ml	0.064
Lab	SL140	stain, Wright's Pack (per slide)	ml	0.048
Lab	SL141	stain, Wright's soln	ml	0.214
Lab	SL142	streptavidin label	ml	3.98
Lab	SL173	sucrose, reagent	gm	0.037
Lab	SL143	test tube	item	0.273
Lab	SL256	ThinPrep UroCyte filter	item	8.5
Lab	SL144	thrombin reagent (Thromboquik)	ml	2.737
Lab	SL202	tissue conditioner, coesoft (0.5 oz, each, liquid and powder)	item	8.54
Lab	SL145	tissue revival soln	ml	0.039
Lab	SL174	Toluidine Blue O (for microscopy)	gm	0.58
Lab		tube, anerobic culture	item	
Lab	SL240	tube, centrifuge, micro, 1.5 ml, DNase free snap lock	item	0.072
Lab	SL241	tube, conical, 15ml	item	0.346
Lab	SL242	tube, hematology, 10ml	item	0.285
Lab	SL146	tubed culture media	item	0.849
Lab	SL243	Tween 20	ul	0.152
Lab	SL175	underpad 2ft x 2ft (lab bench)	item	0.37715
Lab	SL147	uranyl acetate	gm	3.16
Lab	SL203	vial, 10 ml, plastic (-70 degree storage)	item	1.016
Lab	SL204	vial, kimble sample, non sterile, glass, 20 ml	item	0.708
Lab	SL176	vial, specimen-sample, 4ml	item	0.55
Lab	SL244	water, de-ionized	ml	0.017
Lab	SL149	waterbath reagent	ml	0.002
Lab	SL177	wax sheet	item	0.2848
Lab	SL150	wax, bite registration wafer	item	0.323
Lab	SL245	weighing dishes, pour boats	item	0.216
Lab	SL151	xylenes solvent	ml	0.012
NO DETAILS	SX001	ACTIVE	na	
NO DETAILS	SX002	BUNDLED	na	
NO DETAILS	SX003	CARRIER PRICED	na	
NO DETAILS	SX004	CODE NOT COSTED	na	
NO DETAILS	SX006	EXCLUDED BY LAW	na	
NO DETAILS	SX007	NO SUPPLIES	na	
NO DETAILS	SX008	NONCOVERED	na	
NO DETAILS	SX009	NOT VALID	na	
NO DETAILS	SX010	RESTRICTED	na	
Office Supply, Grocery	SK001	ages & stages questionnaire	item	0.4
Office Supply, Grocery	SK002	anatomical drawings (for treatment recording)	item	1.75
Office Supply, Grocery	SK003	aphasia assessment forms, average	item	2.84
Office Supply, Grocery	SK004	apple sauce	oz	0.052
Office Supply, Grocery	SK005	assessment monitoring instruments	item	0.13
Office Supply, Grocery	SK006	assessment-monitoring instruments (50% use)	item	0.065
Office Supply, Grocery	SK007	audio cassette tape 60 min	item	0.76
Office Supply, Grocery	SK008	audiology scoring forms	item	0.088
Office Supply, Grocery	SK009	bath soap (one bar uou)	item	0.686
Office Supply, Grocery	SK010	battery, 9 volt	item	1.794
Office Supply, Grocery	SK095	battery, AA	item	0.45
Office Supply, Grocery	SK011	battery, AAA	item	0.485
Office Supply, Grocery	SK097	canned air (Dust-Off)	oz	1.0208
Office Supply, Grocery	SK012	CDC information sheet	item	0.005
Office Supply, Grocery	SK113	communication, wireless per service	item	57.78
Office Supply, Grocery	SK013	computer media, dvd	item	3.832
Office Supply, Grocery	SK014	computer media, floppy disk 1.44mb	item	0.224
Office Supply, Grocery	SK015	computer media, optical disk 128mb	item	12
Office Supply, Grocery	SK016	computer media, optical disk 2.6gb	item	68.75
Office Supply, Grocery	SK017	cookie (each)	item	0.06
Office Supply, Grocery	SK103	cork sheet, 1cm x 1 cm	item	0.02
Office Supply, Grocery	SK018	cup, drinking	item	0.025
Office Supply, Grocery	SK106	device shipping cost	item	12
Office Supply, Grocery	SK019	diluent, olive oil	ml	0.005
Office Supply, Grocery	SK020	drinking straw	item	0.01
Office Supply, Grocery	SK021	emery board	item	0.083
Office Supply, Grocery	SK112	Federal Express cost (average across all zones)	item	29.56

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Office Supply, Grocery	SK110	fee, image analysis	item	18
Office Supply, Grocery	SK111	fee, licensing, computer, psychology	item	26.83
Office Supply, Grocery	SK107	fee, usage, cycletron/acceleator, gammaknife, Lincac SRS System	min	3.65
Office Supply, Grocery	SK022	film, 8inx10in (ultrasound, MRI)	item	0.92
Office Supply, Grocery	SK024	film, dental	item	0.959
Office Supply, Grocery	SK025	film, dry, radiographic, 8in x 10in	item	0.98
Office Supply, Grocery	SK026	film, Ektachrome 35mm (per exposure)	item	0.285
Office Supply, Grocery	SK028	film, fluoroscopic 14 x 17	item	3.69
Office Supply, Grocery	SK029	film, instant (Polaroid) (per exposure)	item	1.825
Office Supply, Grocery	SK030	film, Tri-x 35mm BW (per exposure)	item	0.19
Office Supply, Grocery	SK032	film, type 667 Polaroid (per exposure)	item	1
Office Supply, Grocery	SK033	film, x-ray 10in x 12in	item	0.623
Office Supply, Grocery	SK034	film, x-ray 14in x 17in	item	1.17
Office Supply, Grocery	SK035	film, x-ray 14in x 36in	item	2.445
Office Supply, Grocery	SK037	film, x-ray 8in x 10in	item	0.461
Office Supply, Grocery	SK038	film, x-ray 8in x 10in (X-omat, Radiomat)	item	1.43
Office Supply, Grocery	SK098	film, x-ray, laser print	item	1.437
Office Supply, Grocery	SK039	foam 3in, therapy positioning (per 1 sq in)	item	0.012
Office Supply, Grocery	SK104	foil, aluminum, 10 cm x 10 cm	item	0.02
Office Supply, Grocery	SK040	graham crackers (one packet)	item	0.697
Office Supply, Grocery	SK041	ice (per cup)	item	0.05
Office Supply, Grocery	SK042	juice, apple	oz	0.039
Office Supply, Grocery	SK043	label for files-folders	item	0.08
Office Supply, Grocery	SK044	lamination sheet (letter size)	item	0.666
Office Supply, Grocery	SK045	lip screen	item	1.44
Office Supply, Grocery	SK046	lotion, massage, unscented	oz	0.158
Office Supply, Grocery	SK047	map, Moh's surgery (per sheet)	item	0.005
Office Supply, Grocery	SK108	MCMI-III kit and manual	item	
Office Supply, Grocery	SK048	measuring tape, paper	item	0.041
Office Supply, Grocery	SK049	nail polish	item	1.99
Office Supply, Grocery	SK050	neurobehavioral status forms, average	item	5.77
Office Supply, Grocery	SK051	pad, feminine maxi	item	0.15
Office Supply, Grocery	SK052	pad, feminine mini	item	0.11
Office Supply, Grocery	SK053	pad, nail polish remover	item	0.044
Office Supply, Grocery	SK054	pad, urinary incontinence (Depends)	item	0.509
Office Supply, Grocery	SK109	paper, articulating	item	0.029
Office Supply, Grocery	SK055	paper, card stock (8.5 x 11)	item	0.035
Office Supply, Grocery	SK056	paper, graph-plotter	item	0.631
Office Supply, Grocery	SK057	paper, laser printing (each sheet)	item	0.005
Office Supply, Grocery	SK058	paper, photo printing (8.5 x 11)	item	0.45
Office Supply, Grocery	SK059	paper, recording (per sheet)	item	0.067
Office Supply, Grocery	SK060	paper, recording, roll (per foot)	foot	0.087
Office Supply, Grocery	SK061	paraffin for therapy bath	lb	3.198
Office Supply, Grocery	SK062	patient education booklet	item	1.55
Office Supply, Grocery	SK099	Photo-Flo soln	ml	0.0214
Office Supply, Grocery	SK065	photographic stop bath	oz	0.01
Office Supply, Grocery	SK066	plastic wrap	foot	0.012
Office Supply, Grocery	SK110	plates, Rorshcach	item	18
Office Supply, Grocery	SK111	plates, Thematic Apperception Test (TAT)	item	26.83
Office Supply, Grocery	SK100	preventive assessment forms	item	3
Office Supply, Grocery	SK067	psych testing forms, average	item	2.3
Office Supply, Grocery	SK068	razor	item	0.389
Office Supply, Grocery	SK070	Rep-band, light (6yd uou)	item	6.12
Office Supply, Grocery	SK071	rubber bands, non-sterile	item	0.02
Office Supply, Grocery	SK072	sandpaper (per sheet)	item	0.398
Office Supply, Grocery	SK073	skin marking ink (tattoo)	ml	0.221
Office Supply, Grocery	SK074	skin marking pen, fluorescent (Spotlighter)	item	1
Office Supply, Grocery	SK075	skin marking pen, sterile (Skin Skribe)	item	1.048
Office Supply, Grocery	SK076	slide sleeve (photo slides)	item	0.192
Office Supply, Grocery	SK077	spoon, plastic	item	0.026
Office Supply, Grocery	SK112	starch, fine	oz	29.56
Office Supply, Grocery	SK078	sunscreen lotion (spf15)	oz	0.599
Office Supply, Grocery	SK079	tape, toupee	inch	0.048
Office Supply, Grocery	SK080	toothbrush	item	0.805
Office Supply, Grocery	SK081	toothpaste	oz	0.498

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Office Supply, Grocery	SK082	towel, paper (Bounty) (per sheet)	item	0.007
Office Supply, Grocery	SK083	transparency	item	0.586
Office Supply, Grocery	SK084	Velcro, standard	foot	0.372
Office Supply, Grocery	SK085	Velcro, strong (Poly-Lock)	foot	2.82
Office Supply, Grocery	SK086	video tape, VHS	item	2.049
Office Supply, Grocery	SK087	water, distilled	oz	0.013
Office Supply, Grocery	SK088	Woodcock Johnson test record	item	2.44
Office Supply, Grocery	SK089	x-ray developer solution	oz	0.096
Office Supply, Grocery	SK090	x-ray digitalization separator sheet	item	1.5
Office Supply, Grocery	SK091	x-ray envelope	item	0.153
Office Supply, Grocery	SK092	x-ray fixer solution	oz	0.087
Office Supply, Grocery	SK093	x-ray ID card (flashcard)	item	0.062
Office Supply, Grocery	SK094	x-ray marking pencil	item	0.938
Pharmacy, NonRx	SJ071	ACD-A anticoagulant	item	6.58
Pharmacy, NonRx	SJ079	adhesive, facial	ml	3
Pharmacy, NonRx	SJ001	alcohol isopropyl 70%	ml	0.002
Pharmacy, NonRx	SJ002	allergen patch test card, T.R.U.E. (24 test card)	item	55.4
Pharmacy, NonRx	SJ003	allergen patch test cell, Finn Chambers (10 cell card)	item	13
Pharmacy, NonRx	SJ004	allergen patch test cell, Finn Chambers (5 cell card)	item	8.6
Pharmacy, NonRx	SJ006	anthralin ointment	gm	2.75
Pharmacy, NonRx	SJ007	bacitracin oint (0.9gm uou)	item	0.091
Pharmacy, NonRx	SJ008	bacitracin oint (15gm uou)	item	1.417
Pharmacy, NonRx	SJ010	basin, emesis	item	0.216
Pharmacy, NonRx	SJ009	basin, irrigation	item	1.542
Pharmacy, NonRx	SJ079	basin, sterile 500cc	item	3
Pharmacy, NonRx	SJ072	brush, disposable applicator	item	0.276
Pharmacy, NonRx	SJ011	bulb syringe (Asepto)	item	0.99
Pharmacy, NonRx	SJ012	Cetacaine spray (56gm size bottle)	gm	0.939
Pharmacy, NonRx		cleanser, cholohexidine (Hibiclens)	ml	
Pharmacy, NonRx	SJ013	coal tar soln	ml	0.024
Pharmacy, NonRx	SJ014	collodion (2oz uou)	item	2.611
Pharmacy, NonRx	SJ065	contact lens (hard) care kit	item	7.95
Pharmacy, NonRx	SJ066	contact lens (hard) extra strength cleaning solution	ml	0.1583
Pharmacy, NonRx	SJ067	contact lens (RGP) polishing soln (Silo2 Care)	ml	0.077
Pharmacy, NonRx	SJ015	contact lens soln (12oz uou)	item	4.19
Pharmacy, NonRx	SJ016	denture cup	item	0.183
Pharmacy, NonRx	SJ073	DMV remover	item	1.99
Pharmacy, NonRx	SJ017	DuraPrep surgical soln (26ml uou)	item	7.95
Pharmacy, NonRx	SJ018	earplugs	pair	0.165
Pharmacy, NonRx	SJ019	electrode adhesive disk	item	0.08
Pharmacy, NonRx	SJ020	electrode conductive gel	ml	0.016
Pharmacy, NonRx	SJ021	electrode conductive paste	oz	1.072
Pharmacy, NonRx	SJ022	electrode skin prep gel (NuPrep)	ml	0.056
Pharmacy, NonRx	SJ023	electrode skin prep tape (One-Step)	inch	0.097
Pharmacy, NonRx	SJ024	electrolyte coupling gel	ml	0.016
Pharmacy, NonRx	SJ025	ethyl chloride spray	oz	4.401
Pharmacy, NonRx	SJ026	Eucerin cream	oz	0.954
Pharmacy, NonRx	SJ027	goggles, uv-blocking	item	2.3
Pharmacy, NonRx	SJ028	hydrogen peroxide	ml	0.003
Pharmacy, NonRx	SJ029	ice pack, instant	item	1.06
Pharmacy, NonRx	SJ030	ipecac syrup (1oz uou)	item	1.885
Pharmacy, NonRx	SJ031	leg or urinary drainage bag	item	3.079
Pharmacy, NonRx	SJ074	lens cleaner	ounce	0.69
Pharmacy, NonRx	SJ080	lens cleaner, daily (Allergan)	ounce	0.42
Pharmacy, NonRx	SJ032	lubricating jelly (K-Y) (5gm uou)	item	0.066
Pharmacy, NonRx	SJ032	lubricating jelly (K-Y) (5gm uou)	oz	0.066
Pharmacy, NonRx	SJ033	lubricating jelly (Surgilube)	oz	0.501
Pharmacy, NonRx	SJ034	methoxsalen 10mg (Oxsoralen)	item	6.156
Pharmacy, NonRx	SJ075	methoxsalen, 10ml vial	item	49.5
Pharmacy, NonRx	SJ035	mineral oil	ml	0.011
Pharmacy, NonRx	SJ080	monoplex eye	item	0.42
Pharmacy, NonRx	SJ036	Monsel's soln	ml	1.297
Pharmacy, NonRx	SJ076	nose pads	item	0.79
Pharmacy, NonRx	SJ037	oxymetazoline nasal spray (Afrin) (15ml uou)	item	1.83
Pharmacy, NonRx	SJ081	paste, pressure indicator	gm	1.04

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Pharmacy, NonRx	SJ082	paste, registration	gm	
Pharmacy, NonRx	SJ038	petroleum jelly	oz	0.281
Pharmacy, NonRx	SJ039	pH buffer solution	ml	0.044
Pharmacy, NonRx	SJ040	phenylephrine 1% nasal spray (NeoSynephrine)	ml	0.333
Pharmacy, NonRx	SJ083	polyurethane sheets (quantity as rolls)	roll	
Pharmacy, NonRx	SJ041	povidone soln (Betadine)	ml	0.008
Pharmacy, NonRx	SJ042	povidone surgical scrub (Betadine)	ml	0.009
Pharmacy, NonRx	SJ043	povidone swabsticks (3 pack uou)	item	0.409
Pharmacy, NonRx	SJ044	pre-thickened juice (4oz uou)	item	0.831
Pharmacy, NonRx	SJ070	rubber cement	ml	0.12
Pharmacy, NonRx	SJ068	saline, viscous (swallow challenge medium)	ml	0.25
Pharmacy, NonRx	SJ077	screws, spectacles	item	0.14
Pharmacy, NonRx	SJ045	sensor strip, skin temperature	item	0.975
Pharmacy, NonRx	SJ046	silver nitrate applicator	item	0.07
Pharmacy, NonRx	SJ047	splint straps 1in	item	1.299
Pharmacy, NonRx	SJ048	splint straps 2in	item	1.525
Pharmacy, NonRx	SJ049	stoma adhesive	oz	4.38
Pharmacy, NonRx	SJ050	stoma pouch and wafer	item	8
Pharmacy, NonRx	SJ051	swab, lemon-glycerine (3 pak uou)	item	0.129
Pharmacy, NonRx	SJ081	swab, patient prep, 1.5 ml (chloraprep)	item	1.04
Pharmacy, NonRx	SJ052	swab, procto 16in	item	0.117
Pharmacy, NonRx	SJ053	swab-pad, alcohol	item	0.013
Pharmacy, NonRx	SJ084	teeth set	item	
Pharmacy, NonRx	SJ078	temple tips	pair	1
Pharmacy, NonRx	SJ069	test strip, glucose (blood test)	item	0.721
Pharmacy, NonRx	SJ054	test strip, glucose-protein (Chemstrip GP, Uristix)	item	0.257
Pharmacy, NonRx	SJ055	test strip, INR	item	21.875
Pharmacy, NonRx	SJ056	Thera-bands (6in width)	foot	0.602
Pharmacy, NonRx	SJ057	thermometer (single use)	item	0.106
Pharmacy, NonRx	SJ058	thick-it pack	item	0.35
Pharmacy, NonRx	SJ059	tincture of benzoin, liquid	ml	0.077
Pharmacy, NonRx	SJ060	tincture of benzoin, swab	item	0.32
Pharmacy, NonRx	SJ061	tongue depressor	item	0.012
Pharmacy, NonRx	SJ085	triad tray material	item	
Pharmacy, NonRx	SJ062	ultrasound transmission gel	ml	0.013
Pharmacy, NonRx	SJ063	urinal	item	2.8967
Pharmacy, NonRx	SJ086	wax, baseplate	gm	
Pharmacy, NonRx	SJ087	wax, boxing	gm	
Pharmacy, NonRx	SJ064	zinc oxide ointment	oz	0.95
Pharmacy, Rx	SH001	acetic acid 5%	ml	0.012
Pharmacy, Rx	SH002	acetylcholine (for patient use)	gm	0.4
Pharmacy, Rx	SH076	adhesive, cyanoacrylate (2ml uou).doc	item	28.988
Pharmacy, Rx	SH003	adrenalin topical	ml	0.97
Pharmacy, Rx	SH004	albumin saline	ml	0.08
Pharmacy, Rx	SH077	albuterol inhal soln (3ml vial)	item	0.436
Pharmacy, Rx	SH006	antigen, mite	ml	4.1
Pharmacy, Rx	SH007	antigen, multi (pollen, mite, mold, cat)	ml	6.7
Pharmacy, Rx	SH008	antigen, single	ml	5.18
Pharmacy, Rx	SH009	antigen, venom	ml	16.67
Pharmacy, Rx	SH010	antigen, venom, tri-vespid	ml	30.22
Pharmacy, Rx	SH011	atropine 1% ophth	ml	0.212
Pharmacy, Rx	SH012	bacitracin powder (Altracin)	gm	3.846
Pharmacy, Rx	SH078	balanced salt soln (BSS) (15ml uou)	item	1.6
Pharmacy, Rx	SH013	barium high density susp (11-12oz uou)	item	3.718
Pharmacy, Rx	SH014	barium paste	oz	1.815
Pharmacy, Rx	SH015	barium sulfate, sterile (Biotrace) (6gm uou)	item	72.5
Pharmacy, Rx	SH016	barium suspension (Polibar)	ml	0.018
Pharmacy, Rx	SH017	barium, honey (Varibar)	ml	0.217
Pharmacy, Rx	SH018	barium, nectar (Varibar)	ml	0.021
Pharmacy, Rx	SH019	barium, pudding (Varibar)	ml	0.217
Pharmacy, Rx	SH020	bone cement (full dose pack uou) (Osteobond, Simplex)	item	75.645
Pharmacy, Rx	SH021	bupivacaine 0.25% inj (Marcaine)	ml	0.254
Pharmacy, Rx	SH022	bupivacaine 0.5% inj (Marcaine)	ml	0.1
Pharmacy, Rx	SH023	chlorhexidine 0.12% (Peridex)	oz	0.408
Pharmacy, Rx	SH024	Cipro HC otic soln	ml	10.23

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Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Pharmacy, Rx	SH025	cocaine 4% solution, topical	ml	3.813
Pharmacy, Rx	SH026	Conray Inj (iothalamate 43%)	ml	0.087
Pharmacy, Rx	SH027	dexamethasone 0.5% oph oint (4gm uou)	item	6.47
Pharmacy, Rx	SH029	effervescent granules (Sparkles, EZ Gas) (4gm uou)	item	2.142
Pharmacy, Rx	SH030	Emla cream	gm	2.089
Pharmacy, Rx	SH032	erythromycin ophth oint (3.5gm uou)	item	2.95
Pharmacy, Rx	SH081	Floxin 0.3% otic soln	ml	2.354
Pharmacy, Rx	SH033	fluorescein inj (5ml uou)	item	5.442
Pharmacy, Rx	SH034	fluorescein strips	item	0.282
Pharmacy, Rx	SH035	fluori-methane (cold spray)	ml	0.422
Pharmacy, Rx	SH036	glycopyrrolate inj (2ml uou)	item	2.097
Pharmacy, Rx	SH037	Goniosol 2.5% ophth	ml	0.58
Pharmacy, Rx	SH038	hemostatic solution (Lumicain)	ml	0.136
Pharmacy, Rx	SH039	heparin 1,000 units-ml inj	ml	0.193
Pharmacy, Rx	SH093	heparin 5,000 units-ml inj	ml	0.5085
Pharmacy, Rx	SH040	heparin lock flush soln	item	1.16
Pharmacy, Rx	SH082	hyaluronic acid viscoelastic inj (Amvisc, 0.5ml uou)	item	61
Pharmacy, Rx	SH041	Indigo Carmine soln 0.8% inj (5cc vial uou)	item	11.88
Pharmacy, Rx	SH042	inhalant	gm	0.788
Pharmacy, Rx	SH044	Iopidine 1% ophth soln (0.1ml uou)	item	11.013
Pharmacy, Rx	SH083	Jessner's soln	ml	0.2396
Pharmacy, Rx	SH084	Kenalog 40 inj	ml	1.83
Pharmacy, Rx	SH045	Laminaria tent	item	3.583
Pharmacy, Rx	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	ml	0.064
Pharmacy, Rx	SH047	lidocaine 1%-2% inj (Xylocaine)	ml	0.035
Pharmacy, Rx	SH048	lidocaine 2% jelly, topical (Xylocaine)	ml	0.647
Pharmacy, Rx	SH049	lidocaine 2% w-epi inj (Xylocaine w-epi)	ml	0.081
Pharmacy, Rx	SH050	lidocaine 4% soln, topical (Xylocaine)	ml	0.153
Pharmacy, Rx	SH092	LMX 4% anesthetic cream	gm	1.6
Pharmacy, Rx	SH052	methylene blue 1% injection	ml	0.65
Pharmacy, Rx	SH053	neomycin-polymyxin-hc otic soln (Cortisporin)	ml	2.006
Pharmacy, Rx	SH096	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	item	175
Pharmacy, Rx	SH055	phenol 1000ppm	ml	0.059
Pharmacy, Rx	SH088	phenol, liquified, USP	ml	0.1354
Pharmacy, Rx	SH056	phenylephrine 2.5% ophth (Mydfrin)	ml	0.391
Pharmacy, Rx	SH097	Pilocarpine 2%	ml	2.853
Pharmacy, Rx	SH057	prednisolone acet 1% oph soln (5ml uou)	item	6.67
Pharmacy, Rx	SH058	proparacaine 0.5% ophth (Ophthaine, Alcaine)	ml	0.596
Pharmacy, Rx	SH095	protamine sulfate 10 mg/ml (5ml uou vial)	item	225
Pharmacy, Rx	SH059	purified protein derivative (0.1ml per test) (PPD-Tubersol)	ml	17.337
Pharmacy, Rx	SH060	renographin-60	ml	0.38
Pharmacy, Rx	SH062	sclerosing solution inj	ml	2.029
Pharmacy, Rx	SH063	Sensorcaine 0.5% inj	ml	0.363
Pharmacy, Rx	SH064	silver sulfadiazene cream (Silvadene)	gm	0.161
Pharmacy, Rx	SH089	skin refrigerant-anesthetic spray (Frigiderm)	oz	5
Pharmacy, Rx	SH090	sodium bicarbonate 8.4% inj w-needle (1ml uou)	item	2.2
Pharmacy, Rx	SH065	sodium chloride 0.9% flush syringe	item	0.811
Pharmacy, Rx	SH066	sodium chloride 0.9% inj (10ml uou)	item	0.427
Pharmacy, Rx	SH067	sodium chloride 0.9% inj (250-1000ml uou)	item	1.708
Pharmacy, Rx	SH068	sodium chloride 0.9% inj bacteriostatic (30ml uou)	item	0.7
Pharmacy, Rx	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	item	2.074
Pharmacy, Rx	SH070	talc, sterile (Sclerosol) (4gm uou)	item	107.5
Pharmacy, Rx	SH071	Telepaque capsule	item	0.745
Pharmacy, Rx	SH072	triamcinolone acetonide 0.1% cream	gm	0.052
Pharmacy, Rx	SH091	trichloroacetic acid 90% (sat soln)	ml	0.855
Pharmacy, Rx	SH073	tropicamide 1% ophth (Mydriacyl)	ml	0.656
Pharmacy, Rx	SH074	water, sterile for irrigation (250-1000ml uou)	item	2.09
Pharmacy, Rx	SH075	water, sterile inj	ml	0.029
Wound Care, Dressings	SG001	adherent, pre-tape spray	oz	0.761
Wound Care, Dressings	SG002	adhesive bonder, orthotic	oz	0.375
Wound Care, Dressings	SG003	adhesive foam	inch	0.122
Wound Care, Dressings	SG004	adhesive liquid (Mastisol) (0.67ml uou)	item	2.166
Wound Care, Dressings	SG005	adhesive remover, liquid (Detachol) (0.67ml uou)	item	2.344
Wound Care, Dressings	SG006	adhesive remover, pad (acetone)	item	0.035
Wound Care, Dressings	SG007	adhesive, skin (Dermabond)	item	30.068

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Wound Care, Dressings	SG008	applicator, cotton-tipped, non-sterile 6in	item	0.007
Wound Care, Dressings	SG081	applicator, cotton-tipped, sterile, 6in	item	0.0562
Wound Care, Dressings	SG009	applicator, sponge-tipped	item	0.139
Wound Care, Dressings	SG010	bandage, elastic wrap 2in (Ace)	item	0.644
Wound Care, Dressings	SG011	bandage, elastic wrap 3in (Ace)	item	0.859
Wound Care, Dressings	SG012	bandage, elastic wrap 4in (Ace)	item	1.179
Wound Care, Dressings	SG013	bandage, elastic wrap 6in (Ace)	item	1.539
Wound Care, Dressings	SG014	bandage, elastic, self-adherent wrap 1in (Coban)	item	1.307
Wound Care, Dressings	SG015	bandage, Esmarch-Martin, sterile 3in x 9ft	item	5.645
Wound Care, Dressings	SG016	bandage, Kerlix, sterile 4.5in	item	1.772
Wound Care, Dressings	SG017	bandage, Kling, non-sterile 2in	item	0.363
Wound Care, Dressings	SG018	bandage, Kling, non-sterile 3in	item	0.506
Wound Care, Dressings	SG019	bandage, Kling, non-sterile 6in	item	0.792
Wound Care, Dressings	SG020	bandage, Kling, sterile 4in	item	1.06
Wound Care, Dressings	SG021	bandage, strip 0.75in x 3in (Bandaid)	item	0.043
Wound Care, Dressings	SG022	bandage, tubular, x-large (Surgilast)	yd	1.606
Wound Care, Dressings	SG023	cast, cutter blade	item	9.34
Wound Care, Dressings	SG025	cast, padding 4in x 4yd (Webril)	item	1.583
Wound Care, Dressings	SG027	cast, stockinette 4in	yd	0.459
Wound Care, Dressings	SG028	cast, stockinette 6in	yd	0.669
Wound Care, Dressings	SG029	casting tape, fiberglass 4in x 4yd	item	12.454
Wound Care, Dressings	SG030	cotton balls, non-sterile	item	0.004
Wound Care, Dressings	SG082	cotton balls, sterile	item	0.0215
Wound Care, Dressings	SG031	cottonoid	item	0.773
Wound Care, Dressings	SG032	dental rolls	item	0.025
Wound Care, Dressings	SG033	dressing, 12-7mm (Gelfoam)	item	10.154
Wound Care, Dressings	SG034	dressing, 3in x 3in (Adaptic)	item	0.516
Wound Care, Dressings	SG035	dressing, 3in x 4in (Telfa, Release)	item	0.144
Wound Care, Dressings	SG036	dressing, 4in x 4.75in (Polyskin)	item	1.335
Wound Care, Dressings	SG037	dressing, 4in x 4.75in (Tegaderm)	item	1.771
Wound Care, Dressings	SG038	dressing, 4in x 4in (Vigilon)	item	4.371
Wound Care, Dressings	SG039	dressing, 5in x 9in (ABD-Combine)	item	0.273
Wound Care, Dressings	SG040	dressing, 5in x 9in (Adaptic)	item	2.318
Wound Care, Dressings	SG041	dressing, 5in x 9in (Xeroform)	item	1.556
Wound Care, Dressings	SG042	dressing, ear (Glasscock)	item	12
Wound Care, Dressings	SG043	dressing, eye pad (Opticlude)	item	0.328
Wound Care, Dressings	SG044	dressing, Merocel nasal standard 4.5cm	item	6.3
Wound Care, Dressings	SG084	dressing, micro-porous (VersaFoam)	item	9.227
Wound Care, Dressings	SG093	dressing, multi layer system, venous ulcer	item	28
Wound Care, Dressings	SG045	dressing, OpSite IV 3000	item	0.603
Wound Care, Dressings	SG046	eye pad, sterile, strabismus	item	0.336
Wound Care, Dressings	SG047	eye shield (fox) and garter	item	0.689
Wound Care, Dressings	SG048	eye shield, fox	item	0.6
Wound Care, Dressings	SG049	eye shield, non-fog	item	0.52
Wound Care, Dressings	SG050	gauze, non-sterile 2in x 2in	item	0.013
Wound Care, Dressings	SG051	gauze, non-sterile 4in x 4in	item	0.035
Wound Care, Dressings	SG052	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	inch	0.003
Wound Care, Dressings	SG053	gauze, sterile 2in x 2in	item	0.057
Wound Care, Dressings	SG054	gauze, sterile 3in x 3in	item	0.093
Wound Care, Dressings	SG055	gauze, sterile 4in x 4in	item	0.159
Wound Care, Dressings	SG056	gauze, sterile 4in x 4in (10 pack uou)	item	0.798
Wound Care, Dressings	SG057	gauze, x-ray detectable, sterile 4in x 4in (10 pack uou)	item	1.473
Wound Care, Dressings	SG085	microsponge, cellulose (10 pack uou)	item	3.62
Wound Care, Dressings	SG058	moleskin 9in width	foot	3.459
Wound Care, Dressings	SG059	oto-wick	item	0.904
Wound Care, Dressings	SG060	outrigger line	yd	0.091
Wound Care, Dressings	SG061	outrigger post	item	0.399
Wound Care, Dressings	SG062	packing, gauze plain 0.25-0.50in (5 yd uou)	item	4.023
Wound Care, Dressings	SG063	packing, gauze plain 1in (5 yd uou)	item	4.42
Wound Care, Dressings	SG064	packing, gauze w-iodoform 0.25-0.5in (5 yd uou)	item	4.08
Wound Care, Dressings	SG065	packing, gauze w-iodoform 1in (5 yd uou)	item	5.215
Wound Care, Dressings	SG066	packing, gauze w-petrolatum, 0.5in (6yd uou)	item	2.027
Wound Care, Dressings	SG092	packing, gauze, plain, 1 in (5 yd uou)	item	6.17
Wound Care, Dressings	SG067	penrose drain (0.25in x 4in)	item	0.497
Wound Care, Dressings	SG068	plaster bandage (4in x 5yd uou)	item	1.862

2011 CMS Direct PE Inputs Medical Supplies Listing				
Category	**CMS Code**	**Description**	**Unit of Measure**	**Purchase Price**
Wound Care, Dressings	SG070	punctum plug	pair	40
Wound Care, Dressings	SG071	scrotal support	item	6.695
Wound Care, Dressings	SG072	septal button prosthesis, silicone	item	76.667
Wound Care, Dressings	SG073	splint, adhesive nasal (Denver)	item	21.2
Wound Care, Dressings	SG086	splint, finger (metal-foam)	item	1.655
Wound Care, Dressings	SG074	steri-strip (6 strip uou)	item	1.116
Wound Care, Dressings	SG087	stockings, knee length, 20-30mm compression	pair	49.673
Wound Care, Dressings	SG075	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	item	1.741
Wound Care, Dressings	SG076	tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou)	item	3.422
Wound Care, Dressings	SG088	tape, foam, elastic, 2in (Microfoam)	inch	0.0026
Wound Care, Dressings	SG089	tape, phix strips (for nasal catheter)	item	1.4
Wound Care, Dressings	SG077	tape, porous-hypoallergenic 2in (Scanpore)	inch	0.017
Wound Care, Dressings	SG078	tape, surgical occlusive 1in (Blenderm)	inch	0.007
Wound Care, Dressings	SG079	tape, surgical paper 1in (Micropore)	inch	0.002
Wound Care, Dressings	SG094	Tisseel Fibrin Glue, 1 ml	ml	262.01
Wound Care, Dressings	SG090	tracheostomy collar-neckband	item	3.235
Wound Care, Dressings	SG091	tracheostomy dressing	item	3.24
Wound Care, Dressings	SG080	unna boot	item	4.561
		disposable aspirating syringe		
	SD224	Filter, Foam Plug (10/Pk)	item	0.36
	SD225	Flutter Valve for Tee-Connector	item	1.26
	SD234	QuinGas-3, 150 H2, 75 CH4, 6% CO2, BreathTracker SC Calibration G	cc	1.218
		ruler, stainless steel		
	SD236	Single Patient Discard Bag, 400 ml	item	1.2
	SD237	Sivrite-4	g	0.086
	SD241	Substrate, D-Xylose, 25 gm Packet	item	10.76
	SC094	Syringe, 35 ml, Monoject, Plastic	item	2.24
	SD242	Tee-Connector, Plastic	item	1.4

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Bone Marrow Stem Cell Transplant

In February 2011, the RUC had a extensive discussion regarding the appropriate Evaluation and Management billing for CPT code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; per allogenic donor*. The specialties explained that the physician work involved in the management of infusion, including managing a reaction, is included in the intra-service work of code 38240. The RUC expressed concern that implementing CCI edits to preclude reporting an Evaluation and Management service on the same date of service would limit the ability for physicians to report the separately identifiable visit prior to the procedure on the same date. Given this, the RUC, and the specialty agreed, that this service should be referred back to the CPT Editorial Panel along with the family of services, CPT codes 38241 and 38242, to examine the current descriptors and descriptions of physician work to ensure these services are currently reported correctly and can be properly valued by the RUC.

In October 2011, the CPT Editorial Panel added introductory language, created one new code to describe hematopoietic progenitor cell boost and revised three existing codes to clarify this family of services.

The specialty societies indicated and the RUC agreed that there is compelling evidence that these services have changed since 1992. The majority of allogeneic transplants are now from unrelated donors which have much greater risk to the patient. Additionally, the typical patient has changed, the population receiving transplants now have acute diseases, such as acute myologic leukemia, acute lympoblastic leukemia, multiple myelomas etc., whereas previously the typical patient had chronic disease.

38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
The RUC reviewed the survey results from 37 bone and marrow transplant physicians and determined that the survey median work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC agreed with the surveyed physician time of 30 minutes pre-time, 60 minutes intra-time and 30 minutes post-service time. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. As part of the intra-service, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA. The RUC also determined that 38240 is more intense and complex than 38241, the autologous transplantation code.

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The RUC compared 38240 to the key reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time) and determined that 38240 requires much more physician time, technical skill, physical effort and psychological stress to perform. For further support the RUC compared 38240 to codes 99223 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 3.86 and 55 minutes intra-service time) and 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)* (work RVU = 3.72 and 45 minutes intra-service time), both which require less physician work and time than the surveyed service. **The RUC recommends a work RVU of 4.00 for CPT code 38240.**

38241 Hematopoietic progenitor cell (HPC); autologous transplantation
The RUC reviewed the survey results from 33 bone and marrow transplant physicians and determined that the survey 25th percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC determined physician time of 18 minutes pre-time, 60 minutes intra-time and 30 minutes post-service time were appropriate to perform this service. This service will require less pre-service time than 38240 since the donor and recipient are the same person. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. Additionally, regarding the intra-service time, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA.

The RUC determined that a work RVU of 3.00 places this service in the proper rank order compared to the allogeneic code 38240. The RUC compared 38241 to code 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* (work RVU = 3.00 and 60 minutes intra-service time) and determined that both services require the same physician work and time to perform. For further support the RUC compared 38241 to code 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU = 3.00 and 60 minutes intra-service time), which requires the same physician work and time as the surveyed service. **The RUC recommends a work RVU of 3.00 for CPT code 38241.**

38243 Hematopoietic progenitor cell (HPC); HPC boost
The RUC reviewed the survey results from 30 bone and marrow transplant physicians and determined that the survey 25th percentile work RVU of 2.13 appropriately accounts for the work required to perform this service. The RUC determined the survey time of 30 minutes pre-time, 45 minutes intra-time and 30 minutes post-service time were appropriate to perform this service. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product

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properly. Additionally, regarding the intra-service time, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA.

The RUC compared 38243 to key reference code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and determined that 38243 requires the 10 minutes more intra-service time but similar physician work to perform. For additional support the RUC compared 38243 to CPT code 70554 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* (work RVU = 2.11) and determined that the surveyed code required similar physician work to perform. **The RUC recommends a work RVU of 2.13 for CPT code 38243.**

38242 Allogeneic lymphocyte infusion
The RUC reviewed the survey results from 31 bone and marrow transplant physicians and determined that the survey 25th percentile work RVU of 2.11 appropriately accounts for the work required to perform this service. The RUC determined the survey time of 30 minutes pre-time, 45 minutes intra-time and 30 minutes post-service time were appropriate to perform this service. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. Additionally, regarding the intra-service time, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA.

The RUC compared 38242 to key reference code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and determined that 38242 requires the 10 minutes more intra-service time but the same physician work to perform. For additional support the RUC compared 38242 to CPT code 70554 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* (work RVU = 2.11) and determined that the surveyed code required the same physician work to perform. The RUC determined that a work RVU of 2.11 places this service in the proper rank order relative to 38243 (recommended work RVU = 2.13 and same physician time). **The RUC recommends a work RVU of 2.11 for CPT code 38242.**

Practice Expense
This service is performed in the facility only and therefore has no direct practice expense inputs.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

38230 Bone marrow harvesting for transplantation; allogeneic

38232 autologous

(For autologous and allogeneic blood-derived peripheral stem cell harvesting for transplantation, see 38205-38206)

(For bone marrow aspiration, use 38220)

Transplantation and Post-Transplantation Cellular Infusions

Hematopoietic cell transplantation (HCT) refers to the infusion of hematopoietic progenitor cells (HPC) obtained from bone marrow, peripheral blood apheresis and/or umbilical cord blood. These procedure codes (38240-38242) include physician monitoring of multiple physiologic parameters, physician verification of cell processing, evaluation of the patient during as well as immediately before and after the HPC/lymphocyte infusion, physician presence during the HPC/lymphocyte infusion with associated direct physician supervision of clinical staff, and management of uncomplicated adverse events (eg, nausea, urticaria) during the infusion, which is not separately reportable.

HCT may be autologous (when the HPC donor and recipient are the same person) or allogeneic (when the HPC donor and recipient are not the same person). Code 38241 is used to report any autologous transplant while 38240 is used to report an allogeneic transplant. In some cases allogeneic transplants involve more than one donor and cells from each donor are infused sequentially whereby one unit of 38240 is reported for each donor infused. Code 38242 is used to report a donor lymphocyte infusion. Code 38243 is used to report a HPC boost from the original allogeneic HPC donor. A lymphocyte infusion or HPC boost can occur days, months or even years after the initial hematopoietic cell transplant. The lymphocyte infusion is used to treat relapse, infection, or post-transplant lymphoproliferative syndrome. HPC boost represents an infusion of hematopoietic progenitor cells from the original donor that is being used to treat a relapse or post-transplant cytopenia(s). Codes 38240, 38243 and 38242 should not be reported together on the same date of service.

If a separately identifiable evaluation and management service is performed on the same date of service, the appropriate E/M service code, including office or other outpatient services, established (99211-99215), initial observation care (99218-99220), observation care discharge services (99217), subsequent observation care (99224-99226), initial hospital care (99221-99223), subsequent hospital care (99231-99233), observation or inpatient hospital care (99234-99236), hospital discharge services (99238, 99239), inpatient neonatal and pediatric critical care (99471, 99472, 99475, 99476) may be reported, using modifier 25, in addition to 38240, 38243 or 38242. Post-transplant infusion management of adverse reactions is reported separately utilizing the appropriate E/M, prolonged service or critical care code(s). In accordance with place of service and facility reporting guidelines, the fluid used to administer the cells and other infusions for incidental hydration (eg, 96360, 96361) are not separately reportable. Similarly, infusion(s) of any medication(s) concurrently with the transplant infusion are not separately reportable. However, hydration or administration of medications (eg, antibiotics, narcotics) unrelated to the transplant are separately reportable using modifier 59.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲38240	J1	~~Bone marrow or blood-derived peripheral stem~~ Hematopoietic progenitor cell ~~transplantation~~ (HPC); allogeneic transplantation~~,~~ per donor	XXX	4.00
▲38241	J2	autologous transplantation	XXX	3.00
#●38243	J3	HPC boost	XXX	2.13
▲38242	J4	Allogeneic ~~donor~~ lymphocyte infusions *(For bone marrow aspiration, use 38220)* (For modification, treatment, and processing of ~~bone marrow or blood-derived stem~~ hematopoietic progenitor cell specimens for transplantation, use 38210-3821~~3~~5) (For cryopreservation, freezing, and storage of ~~blood-derived stem~~ hematopoietic progenitor cells for transplantation, use 38207) (For thawing and expansion of ~~blood-derived stem~~ hematopoietic progenitor cells for transplantation, see 38208, 38209) (For compatibility studies, see 81379-81383, 86812-86822)	XXX	2.11
86950		Leukocyte transfusion (For allogeneic lymphocyte infusion use 38242)		

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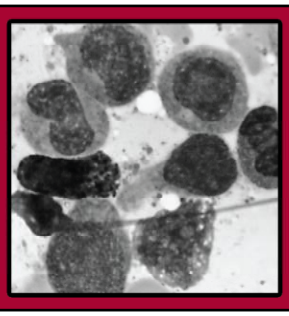

ASBMT™

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Salt Lake City, Utah

2014 Annual Meeting
February 19-23
Dallas, Texas

April 5, 2012

Barbara Levy, MD.
Chair, AMA/Specialty Society RVS Update Committee
515 North State Street
Chicago, IL 60654

Dear Dr. Levy:

We are pleased to present the Summary of Work for the family of Hematopoietic Progenitor Cell (HPC) infusion codes 38240 – 38242 (Tab 16, J1 – J4). As part of our submission, we are also providing a brief history of how the family of codes came to be surveyed, along with information on how the surveys were conducted (i.e., that the new language added to CPT was included with the survey).

The American Society for Blood and Marrow Transplantation (ASBMT) requested changes for CPT 38240 at the October 2010 meeting of the CPT Editorial Panel for review by the RUC in February 2011. Transplant procedures have evolved to sometimes include the infusion of cells from multiple donor sources. The ASBMT sought, and the CPT Panel agreed, to amend the code description to include "per donor" language (38240 – bone marrow or blood-derived peripheral stem cell transplantation; per allogeneic donor).

This revised CPT code went on to survey and data was presented at the February 2011 RUC meeting. The RUCs summary follows:

The RUC had an extensive discussion regarding the appropriate Evaluation and Management billing for CPT code 38240 Bone marrow or blood-derived peripheral stem cell transplantation; per allogeneic donor. The specialties explained that the physician work involved in the management of infusion, including managing a reaction, is included in the intra-service work of code 38240. The RUC expressed concern that implementing CCI edits to preclude reporting an Evaluation and Management service on the same date of service would limit the ability for physicians to report the separately identifiable visit prior to the procedure on the same date. Given this, the RUC, and the specialty agreed, that this service should be referred back to the CPT Editorial Panel along with the family of services, CPT codes 38241 and 38242, to examine the current descriptors and descriptions of physician work to ensure these services are currently reported correctly and can be properly valued by the RUC.

Subsequently, the ASBMT Coding Committee and staff consulted with CMS and AMA staff and presented changes via a CCP to the CPT descriptors for the full family of CPT Codes 38240 – 38241. This review included the substantial addition of introductory language, updated terminology that corresponds with industry standards, and the addition of a fourth CPT code (3824x1) to differentiate lymphocyte infusion from a stem cell boost. The new language is listed below:

Category I
Surgery
Hemic and Lymphatic Systems
General
Bone Marrow or Stem Cell Services/Procedures

38230 Bone marrow harvesting for transplantation; Allogeneic

38232 Autologous

(For autologous and allogeneic blood-derived peripheral stem cell harvesting for transplantation, see 38205- 38206)

(For bone marrow aspiration, use 38220)

Transplantation and Post-Transplantation Cellular Infusions

Hematopoietic cell transplantation (HCT) refers to the infusion of hematopoietic progenitor cells (HPC) obtained from bone marrow, peripheral blood apheresis and/or umbilical cord blood. These procedure codes (38240-38242) include physician monitoring of multiple physiologic parameters, physician verification of cell processing, evaluation of the patient during as well as immediately before and after the HPC/lymphocyte infusion, physician presence during the HPC/lymphocyte infusion with associated direct physician supervision of clinical staff and management of uncomplicated adverse events (e.g., nausea, urticaria) during the infusion, which is not separately reportable.

HCT may be autologous (when the HPC donor and recipient are the same person) or allogeneic (when the HPC donor and recipient are not the same person). Code 38241 is used to report an autologous transplant while 38240 is used to report an allogeneic transplant. In some cases allogeneic transplants involve more than one donor and cells from each donor are infused sequentially whereby one unit of 38240 is reported for each donor infused. Code 38242 is used to report a donor lymphocyte infusion. Code 3824X1 is used to report a HPC boost from the original allogeneic HPC donor. A lymphocyte infusion or HPC boost can occur days, months or even years after the initial hematopoietic cell transplant. The lymphocyte infusion is used to treat relapse, infection, or post-transplant lymphoproliferative syndrome. HPC boost represents an infusion of hematopoietic progenitor cells from the original donor that is being used to treat a relapse or post-transplant cytopenia(s). Codes 38240, 3824X1 and 38242 should not be reported together on the same date of service.

If a separately identifiable evaluation and management service is performed on the same date of service, the appropriate E/M service code, including office or other outpatient services, established (99211-99215), initial observation care (99218-99220), observation care discharge services (99217), subsequent observation care (99224-99226), initial hospital care (99221-99223), subsequent hospital care (99231-99233), observation or inpatient hospital care (99234-99236), hospital discharge services (99238, 99239), inpatient neonatal and pediatric critical care (99471, 99472, 99475, 99476) may be reported, using modifier 25, in addition to 38240, 3824X1 or 38242. Post-transplant infusion management of adverse reactions is reported separately utilizing the appropriate E/M, prolonged service or critical care code(s). In accordance with place of service and facility reporting guidelines, the fluid used to administer the cells and other infusions for incidental hydration (e.g., 96360, 96361) are not separately reportable. Similarly, infusion(s) of any medication(s) concurrently with the transplant infusion are not separately reportable. However, hydration or administration of medications (e.g., antibiotics, narcotics) unrelated to the transplant are separately reportable using modifier 59.

▲38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor

▲38241 Autologous transplantation

#●3824X1 HPC boost

▲38242 Allogeneic lymphocyte infusion

(For bone marrow aspiration, use 38220)

(For modification, treatment, and processing of hematopoietic progenitor cell specimens for transplantation, use 38210-38215)

(For cryopreservation, freezing, and storage of hematopoietic progenitor cells for transplantation, use 38207)

(For thawing and expansion of hematopoietic progenitor cells for transplantation, see 38208, 38209)

(For compatibility studies, see 81379-81383, 86812-86822)

Category I

Pathology and Laboratory
Transfusion Medicine

86950 Leukocyte transfusion

(For allogeneic lymphocyte infusion use 38242)

The ASBMT feels these changes presented at the October 2011 CPT Editorial Panel further clarify the physicians work and ensure accurate reporting of the services. This new language, in its entirety, was included in the survey for this family of codes. Therefore, ASBMT believes that the survey respondents should have valued these codes appropriately and not included work or time that is part of any evaluation and management service performed on the same date. The language added to CPT specifies the activities included in this family of codes. The work begins when the physician does a transplant-specific patient evaluation and verifies proper cell processing. The work ends when the physician performs an evaluation at the end of the infusion. The CPT language clearly excludes any work performed before the pre-transplant evaluation of the patient and after the end of the transplant infusion. Therefore, there should be no overlap between (1) the work of these codes and work related to an evaluation and management service performed earlier in the day (e.g., a subsequent hospital visit) and (2) any work performed after the infusion (e.g., treatment of adverse events that occur post-transplant infusion).

Thank you for considering this information as you evaluate our SORs. We appreciate the opportunity to review these codes and look forwards to discussing them further at the April RUC Meeting.

Sincerely,



James Gajewski, MD
Chair, ASBMT Committee on Reimbursement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38240 Tracking Number J1 Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **4.00**
Global Period: XXX RUC Recommended RVU: **4.00**

CPT Descriptor: Hematopoietic progenitor ell (HPC); allogeneneic transplantation per donor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 40-year old female with acute myelogenous leukemia who has relapsed after obtaining a remission. An allogeneic HPC transplant is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting?

Description of Pre-Service Work: This services includes physician evaluation of the patient immediately before HPC infusion monitoring of multiple physiologic parameters and physician verification of cell processing. The physician confirms recipient and stem cell product identities, compares donor and recipient HLA typing results with previous records, acknowledges and documents ABO matching or mismatching for each respective donor unit, and reviews transplant cross-match when available. Reviews and confirms donor and recipient infectious disease testing. Confirms cell processing for either RBC or plasma depletion or mononuclear cell concentration given the donor/recipient incompatibility. The nurse, physician and cell processing technologist review cell product label, identity, sterility testing, cell dose, and processing. Signs orders for the preparatory pre-transplant medications for anaphylaxis such as epinephrine, atropine and dopamine are at bedside and immediately available if needed as well as to minimize risk of graft rejection or Graft vs. Host Disease (GVHD) with the infusion.

Description of Intra-Service Work: Supervises initiation of product infusion. Physician is present for the first 15 - 30 minutes and remains immediately available to manage toxicities and complications occurring during the infusion. The physician evaluates the patient at the end of the infusion.

Description of Post-Service Work: The physician documents the entire procedure including the pre-infusion evaluation, verification of cell processing and appropriateness for transplant, the infusion, any intra-infusion adverse events, and the post infusion evaluation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	James Gajewski & Sam Silver				
Specialty(s):	American Society of Blood and Marrow Transplant (ASBMT)				
CPT Code:	38240				
Sample Size:	1323	**Resp N:**	37	**Response:** 2.7 %	
Description of Sample:	ASBMT member physicians				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	40.00	1200.00
Survey RVW:	1.00	2.47	**4.00**	4.00	11.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	40.00	**60.00**	70.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	38240	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**0.00**	**30.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.17	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key compontents: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,650,555

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77427	XXX	3.37	**RUC Time**	1,194,406

CPT Descriptor 2 Radiation treatment management, 5 treatments

Other Reference CPT Code	Global	Work RVU	Time Source
95978	XXX	3.50	**RUC Time**

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 21.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 38240**	**Key Reference CPT Code:** 99205	**Source of Time** **RUC Time**
Median Pre-Service Time	30.00	7.00	
Median Intra-Service Time	60.00	45.00	

Median Immediate Post-service Time	30.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**120.00**	**67.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.75	4.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.75	4.50
Urgency of medical decision making	4.25	4.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.63	4.50
Physical effort required	4.25	4.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.75	4.50
Outcome depends on the skill and judgment of physician	4.75	4.75
Estimated risk of malpractice suit with poor outcome	3.63	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.88	4.75
Intra-Service intensity/complexity	4.88	4.63
Post-Service intensity/complexity	4.50	4.38

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An ASBMT RVS panel reviewed and discussed the survey results for each code and then reviewed the entire family to address the issue of relativity within the family. There were 37 respondents and 89 percent of the survey respondents indicated that the vignette was typical.

The panel observed that the survey medians for the four codes were high and also did not accurately reflect their relativity. The panel agreed that the survey 25th percentile RVW for 38240 is too low and is a clear rank order anomaly compared to the other 25th percentile values. The panel believed this was due, in part, to the low volume of respondents for this low volume procedure. In addition, physicians performing Hematopoietic Progenitor Cell (HPC) infusions typically work in academic settings and perform only a limited number of services specifically associated with HPC transplant in the Medicare population.

The survey performance rate median of 20 procedures/infusions per year among the 37 respondents is low, but understandable given that this is a low volume procedure. The ASBMT panel agreed that the survey median times of 30 minutes of pre-service, 60 minutes of intra-service, and 30 minutes of post-service accurately represented the time required to perform this service.

The panel also observed that 38240 has never been valued by the RUC and has an assigned RVW of 2.24 with an assigned total time of 53 minutes. The ASBMT panel believed that these assigned values were too low. Therefore, the current change in CPT language to better describe the service as being per allogeneic donor infusion and to better define the distinction between physician work in the management of the infusion(s), and the separately identifiable visit prior to the procedure on the same date was timely and appropriate. Please see our cover letter for a more complete discussion of this issue.

Compelling Evidence for RVW Increase:
Codes 38240 and 38241 currently have a CMS/other value of 2.24 as well as 53 minutes of assigned total time. We are recommending RVW increases in both codes. In addition 38242 was reviewed by the RUC in 2002 and has an RVW of 1.71 with physician time of 30/30/20 and we are recommending an RVW increase for this procedure as well.

With respect to 38240 and 38241, it is important to note that these codes have never had a vignette, a service description, or been surveyed or reviewed by the RUC. The work values are based upon an assigned time of 53 total minutes (which have never been RUC approved either). In our view this code has never been properly valued and we request that the RUC review this code as if it was a new code.

Furthermore, the patient population receiving allogeneic and autologous transplants has changed over the last 10-15 years and is now comprised largely of older patients with leukemia, myeloma and other hematologic malignancies who are in serious or critical condition because they have just received ablative chemotherapy completely wiping out their bone marrow.

The typical patient has changed significantly since the valuation of these codes (1995 for 38240 and 38241; 2002 for 38242). Allogeneic patients prior to 1995 almost always received HLA identical sibling transplants. The recipients were also primarily younger recipients, as the maximum recipient age at that point in time was age 40-45. We now will routinely do transplants on recipients aged 65-80, whether autologous or allogeneic. On the day of transplant, these patients are being actively managed for complications of the chemotherapy and radiation therapy regimens administered on prior days, such as dehydration and electrolyte imbalances as well as for infection management which is a consequence of the pancytopenia and the underlying leukemia, lymphoma or myeloma malignancy for which they are having the transplant. The allogeneic transplant recipients for code 38240 and 3824x1 are already on immunosuppressive drug therapy which routinely causes electrolyte deficiency, hypertension, and the need for antibiotics for infection management. Additionally, these older patients have co-morbidities such as heart disease and

diabetes. Post infusion documentation of the infusion report has increased in complexity due to increasing regulatory reporting requirements. The transplant infusion is the source documentation for this regulatory reporting.

At the time of the 1995 valuation, the unrelated donor registry was very small (approx. 30,000-50,000 donors). It was the rare patient that had an unrelated donor match. Public umbilical cord blood banking for the purposes of allogeneic transplant did not exist. Now, approximately 60% of transplants are from unrelated donors or cord blood donors, with the remainder from HLA identical siblings. We are also seeing a rise in haplo-identical, half-matched relative transplants. With mismatched transplants, we have the additional issues of graft rejection and ABO incompatibility between donor(s) and recipient. Both of these create increased potential for acute toxicity. We also have a greater potential for minor red cell antigen mismatching causing acute febrile reactions. Additionally, as most donors are harvested with peripheral blood stem cell harvest, we also have increased risk of TRALI, an acute white cell reaction causing acute pulmonary decompensation.

These same clinical issues apply for 38242 which is a subsequent infusion of donor lymphocytes to previously transplanted patients for the treatment of relapse after transplantation for a myeloproliferative disorder.

With the changes in technology and patient population, the current RVWs do not adequately describe the physician work effort for any of these procedures. The physician must now be present to identify the recipient and donor, to review donor/recipient HLA typing, review and make sure the correct cell processing has occurred and review infectious disease status in the donor and recipient. A physician is usually at the bedside for the initial 15 minutes to half hour of the infusion and then every five to fifteen minutes thereafter and is immediately available during the entire infusion to manage complications should they occur. Complications can occur during infusion or well after the infusion. Fluid management is now much more important due to the higher volumes of cells being infused (especially during unrelated donor transplants) which results in a higher risk of fluid overload and congestive heart failure in these older patients. For this reason, the typical time for the infusion has increased. Almost all of these patients are on continuous EKG, blood pressure and pulse oximetry monitoring during the infusion. Post infusion documentation has increased in complexity due to more burdensome regulatory reporting requirements. The transplant infusion is the source documentation for this regulatory reporting.

In addition, the consent process has changed considerably since these codes were developed because of the changes in recipients, donors and risks of the transplantation process. Unrelated donors cannot be forced to donate and can back out immediately before transplant. As this leaves the recipient in a precarious state, the infusion consent process requires a lengthy discussion of risks. The use of unrelated donor cells usually means the cells are harvested elsewhere and transported to the center in which the recipient is admitted. Due to the use of fresh cells for infusion, the cells frequently arrive in the evening or in the middle of the night, necessitating an infusion shortly after arrival. We try to get the cells into the recipient's body within 24 hours after taking them from the donor.

The survey results for 38240 were a median RVW of 4.0 and pre, intra and post services times of 30/60/30. The key reference service was CPT 99205, *office or other outpatient visit for the evaluation and management of a new patient*, (RVW 3.17 times 7, 45, 15). The intensity/complexity measures for 38240 were either similar to or greater than those for 99205.

Interestingly, the results of the survey for 38240, done last year were a median RVW of 3.5 and times of 55/60/30. We believe that the reduction in pre-service time from 55 to 30 minutes supports our belief that the clarifying language in CPT enabled respondents to differentiate the work of this code from the E/M. Specifically, it appears that the overlap was in the pre-service time and work because the intra and post service times were unchanged from the last survey. As the panel reviewed this family of codes it kept in mind that even though an E/M has been performed earlier, the physician must evaluate the patient again to make sure the transplant can be performed. This includes chart review, an interim history, and a brief physical exam. The physician then must ensure that the stem cells have been properly processed, tested and handled and then must be present while the infusion is initiated and, at minimum, for the next 15-20 minutes and then must be immediately available to intervene in case of an adverse event. In this respect, the service is similar to critical care, albeit less intense. Therefore, the fact that an E/M has been performed earlier in the day, does not reduce the work of this service which is entirely different than the work of an E/M.

The ASBMT is asking and RVW of 3.5 which is between the median and 25th percentile of the survey. This appropriately values this service and places it in the correct rank order with the other codes in this family, 38241, 38242 and 3824x1. Specifically, 38240 has more pre-service work than 38241 due to review of both donor and recipient data. 38240 also requires more premedication because of the drugs needed to manage graft rejection which is not an issue with 38241 (autologous transplant). Therefore, the work of 38240 is more intense than that of 38241.

This request also puts it in the correct rank order with 99205, the reference service code, which was chosen by 22 percent of survey respondents.

We also looked at other RUC valued codes with XXX globals:

- 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit, has 3.86 work RVUs and times of 15/55/20
- 99233, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit, has 2.0 work RVUs and times of 10/30/15
- 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, has a work RVU of 4.5 and times of 15/40/15
- 77427, Radiation treatment management, 5 treatments, has a work RVU of 3.37 and times of 7/70/10
- 90962, End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month with a work RVU of 3.15 and 63 minutes of total time (all intra-service)
- 95953, Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended with a work RVU of 3.08 and times of 10/45/15
- 95978, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour with a work RVU of 3.5 and times of 5/60/5
- 36147, Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava) with a work RVU of 3.72 and times of 20/45/15

We believe the times and RVWs from all these codes support our request. Specifically,

- 38240 has longer pre, intra and post times than 99205 (3.17 RVW) and is slightly more intense. This was the key reference service.
- 38240 has longer times than 99223 (3.86 RVW) (30/60/30 vs. 15/55/20) but is less intense.
- 38240 is twice as long as 99233 (2.0 RVW) (30/60/30 vs. 10/30/15) and has similar intensity.
- 38240 has the same intra-service time as 95978 (60 minutes) and is of similar intensity. 95978 involves the analysis and programming of a deep brain neurostimulator. Having the same RVW would place these two services in correct rank order.
- 38240 requires more time than 99291 (4.5 RVW) (30/60/30 vs. 15/40/15) but is less intense.

In addition the requested RVW of 3.5 places it in the current rank order with 77427 (3.37 RVW with 70 minutes of intra-service time) because it has considerably longer pre and post-service time. It is also in the correct rank order with 90962 (3.15 RVW and 63 minutes of total/ intra-service time), 95953 (3.08 RVW with 45 minutes of intra-service time), and 36147, which is a procedure and is more intense than 38240 and has an RVW of 3.72 with 45 minutes of intra-service time.

In summary, to maintain rank order we recommend an RVW of 3.5 which is in-between our median and 25th percentile survey value. Our recommendation is also consistent with our survey data from the February 2011 presentation at the RUC. For service times we recommend the median survey times for 38240 with a pre-service time 30 minutes, intra-service time 60 minutes and post-service time 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is not reported using multiple CPT codes. However, an evaluation and management code is typically reported on the same say as the transplant code because these patients are usually hospitalized and are being seen every day by the transplant physician or another physician, who is also the attending physician in charge of that patient's care. For example, these patients have had their bone marrow ablated and are pancytopenic. They need to managed for their pancytopenia, infections and fluid intake. This management is entirely separate from performing a transplant. In those cases where the transplant physician is also the attending physician, that physician will report the transplant code and an evaluation and management code – usually 99232, 99233 or 99291on the same date. On those rare occasions when a transplant is performed on an outpatient basis, no evaluation and management service is reported.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Please see answer to question 1 and the rationale.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38240

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology/Oncology How often? Commonly

Specialty Medical Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8145
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the Center for International Blood and Marrow Transplant Research (CIBMTR), there are approximately 6000 allogeneic transplants each year in the United States. All of the transplants would require an infusion.

Specialty Hematology/Oncology Frequency 6145 Percentage 75.44 %

Specialty Medical Oncology Frequency 2000 Percentage 24.55 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 377
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database Medicare Claims data

Specialty Hematology/Oncology Frequency 282 Percentage 74.80 %

Specialty Medical Oncology Frequency 95 Percentage 25.19 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 38240

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38241 Tracking Number J2 Original Specialty Recommended RVU: **3.00**
Presented Recommended RVU: **3.00**
Global Period: XXX RUC Recommended RVU: **3.00**

CPT Descriptor: Hematopoietic progenitor cell (HPC); autologous transplantation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 68-year-old man with non Hodgkin's lymphoma in second remission. Patient has co-morbidities of ischemic heart disease, diabetes and a recently treated aspergilloma. An autologous HPC transplant is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting?

Description of Pre-Service Work: This services includes physician evaluation of the patient immediately before HPC infusion, monitoring of multiple physiologic parameters and physician verification of cell processing. The recipient is placed on bedside telemetry, continuous pulse oximetry and continuous blood pressure monitoring. The attending physician and nurse review the premedication. The nurse, physician and cell processing technologist review cell product label, identity, sterility testing, cell dose, processing, DMSO contamination and precise time of washing as cells must be infused within 1 hour of washing. The physician and nurse ensure medications for anaphylaxis such as epinephrine, atropine and dopamine are at bedside and immediately available if needed.

Description of Intra-Service Work: Supervises initiation of product infusion. Physician is present for the first 15 - 30 minutes and remains immediately available to manage toxicities and complications occurring during the infusion. The physician evaluates the patient at the end of the infusion.

Description of Post-Service Work: The physician documents the entire procedure including the pre-infusion evaluation, verification of cell processing and appropriateness for transplant, the infusion, any intra-infusion adverse events, and the post infusion evaluation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	James Gajewski & Sam Silver				
Specialty(s):	ASBMT				
CPT Code:	38241				
Sample Size:	1326	**Resp N:**	33	**Response:** 2.4 %	
Description of Sample:	ASBMT member physicians				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	30.00	900.00
Survey RVW:	0.97	3.00	**3.50**	4.00	11.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**60.00**	60.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	38241	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.17	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key compontents: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77427	XXX	3.37	**RUC Time**	1,194,406

CPT Descriptor 1 Radiation treatment management, 5 treatments

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.61	**RUC Time**	7,451,228

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
95978	XXX	3.50	**RUC Time**

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 24.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 38241**	**Key Reference CPT Code:** 99205	**Source of Time** **RUC Time**
Median Pre-Service Time	18.00	7.00	
Median Intra-Service Time	60.00	45.00	

Median Immediate Post-service Time	30.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**108.00**	**67.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.88	4.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.88	4.38
Urgency of medical decision making	4.38	4.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.38	4.25
Physical effort required	4.00	3.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.75	4.38
Outcome depends on the skill and judgment of physician	4.75	4.50
Estimated risk of malpractice suit with poor outcome	3.88	3.88

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.75	4.63
Intra-Service intensity/complexity	4.38	4.25
Post-Service intensity/complexity	4.00	3.88

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An ASBMT RVS panel reviewed and discussed the survey results for each code and then reviewed the entire family to address the issue of relativity within the family. There were 33 respondents and 88 percent of the survey respondents indicated that the vignette was typical.

The panel observed that the survey medians for the four codes were high and also did not accurately reflect their relativity. However, with the exception of 38240, the 25th percentile of the survey accurately valued the codes and their rank order. This observation of relativity within the family of codes lends credibility to the survey data - particularly the 25th percentile, except for 38240. While the median for Code 38240 is in the appropriate rank order as compared to the median values for the other codes, it is too high. On the other hand, the panel agreed that the survey 25th percentile RVW for 38240 is too low and is a clear rank order anomaly compared to the other 25th percentile values. The panel believed this was due, in part, to the low volume of respondents for this low volume procedure. In addition, physicians performing Hematopoietic Progenitor Cell (HPC) infusions typically work in academic settings and perform only a limited number of services specifically associated with HPC transplant in the Medicare population.

The survey performance rate median of 20 procedures/infusions per year among the 33 respondents is an understandable rate give this is a low volume procedure. The ASBMT panel agreed that the survey median time of 30 minutes of pre-service, 60 minutes of intra-service, and 30 minutes of post-service time accurately reflect the time required to perform this service.

The current CPT code 38241 has an assigned RVW of 2.24 with a total time of 53 minutes. The ASBMT panel believed that the assigned value was too low. Therefore, the reasons for the current change in CPT language to better describe the services within the family of HPC infusion codes and to better define the distinction between physician work in the management of the infusion, and the separately identifiable visit prior to the procedure on the same date was timely and appropriate. As the panel reviewed this family of codes it kept in mind that even though an E/M has been performed earlier, the physician must evaluate the patient again to make sure the transplant can be performed. This includes chart review, an interim history, and a brief physical exam. The physician then must ensure that the stem cells have been properly processed, tested and handled and then must be present while the infusion is initiated and, at minimum, for the next 15-20 minutes and then must be immediately available to intervene in case of an adverse event. In this respect, the service is similar to critical care, albeit less intense. Therefore, the fact that an E/M has been performed earlier in the day, does not reduce the work of this service which is entirely different than the work of an E/M.

Compelling Evidence for RVW Increase:
Codes 38240 and 38241 currently have a CMS/other value of 2.24 as well as 53 minutes of assigned total time. We are recommending RVW increases in both codes. In addition, 38242 was reviewed by the RUC in 2002 and has an RVW of 1.71 with physician time of 30/30/20 and we are recommending an RVW increase for this procedure as well.

With respect to 38240 and 38241, it is important to note that these codes have never had a vignette, a service description, or been surveyed or reviewed by the RUC. The work values are based upon an assigned time of 53 total minutes (which have never been RUC approved either). In our view this code has never been properly valued and we request that the RUC review this code as if it was a new code.

Furthermore, the patient population receiving allogeneic and autologous transplants has changed over the last 10-15 years and is now comprised largely of older patients with leukemia, myeloma and other hematologic malignancies who are in serious or critical condition because they have just received ablative chemotherapy completely wiping out their bone marrow.

The typical patient has changed significantly since the valuation of these codes (1995 for 38240 and 38241; 2002 for 38242). Allogeneic patients prior to 1995 almost always received HLA identical sibling transplants. The recipients were

also primarily younger recipients, as the maximum recipient age at that point in time was age 40-45. We now will routinely do transplants on recipients aged 65-80, whether autologous or allogeneic. On the day of transplant, these patients are being actively managed for complications of the chemotherapy and radiation therapy regimens administered on prior days, such as dehydration and electrolyte imbalances as well as for infection management which is a consequence of the pancytopenia and the underlying leukemia, lymphoma or myeloma malignancy for which they are having the transplant. The allogeneic transplant recipients for code 38240 and 3824x1 are already on immunosuppressive drug therapy which routinely causes electrolyte deficiency, hypertension, and the need for antibiotics for infection management. Additionally, these older patients have co-morbidities such as heart disease and diabetes. Post infusion documentation of the infusion report has increased in complexity due to increasing regulatory reporting requirements. The transplant infusion is the source documentation for this regulatory reporting.

At the time of the 1995 valuation, the unrelated donor registry was very small (approx. 30,000-50,000 donors). It was the rare patient that had an unrelated donor match. Public umbilical cord blood banking for the purposes of allogeneic transplant did not exist. Now, approximately 60% of transplants are from unrelated donors or cord blood donors, with the remainder from HLA identical siblings. We are also seeing a rise in haplo-identical, half-matched relative transplants. With mismatched transplants, we have the additional issues of graft rejection and ABO incompatibility between donor(s) and recipient. Both of these create increased potential for acute toxicity. We also have a greater potential for minor red cell antigen mismatching causing acute febrile reactions. Additionally, as most donors are harvested with peripheral blood stem cell harvest, we also have increased risk of TRALI, an acute white cell reaction causing acute pulmonary decompensation.

These same clinical issues apply for 38242 which is a subsequent infusion of donor lymphocytes to previously transplanted patients for the treatment of relapse after transplantation for a myeloproliferative disorder.

With the changes in technology and patient population, the current RVWs do not adequately describe the physician work effort for any of these procedures. The physician must now be present to identify the recipient and donor, to review donor/recipient HLA typing, review and make sure the correct cell processing has occurred and review infectious disease status in the donor and recipient. A physician is usually at the bedside for the initial 15 minutes to half hour of the infusion and then every five to fifteen minutes thereafter and is immediately available during the entire infusion to manage complications should they occur. Complications can occur during infusion or well after the infusion. Fluid management is now much more important due to the higher volumes of cells being infused (especially during unrelated donor transplants) which results in a higher risk of fluid overload and congestive heart failure in these older patients. For this reason, the typical time for the infusion has increased. Almost all of these patients are on continuous EKG, blood pressure and pulse oximetry monitoring during the infusion. Post infusion documentation has increased in complexity due to more burdensome regulatory reporting requirements. The transplant infusion is the source documentation for this regulatory reporting.

In addition, the consent process has changed considerably since these codes were developed because of the changes in recipients, donors and risks of the transplantation process. Unrelated donors cannot be forced to donate and can back out immediately before transplant. As this leaves the recipient in a precarious state, the infusion consent process requires a lengthy discussion of risks. The use of unrelated donor cells usually means the cells are harvested elsewhere and transported to the center in which the recipient is admitted. Due to the use of fresh cells for infusion, the cells frequently arrive in the evening or in the middle of the night, necessitating an infusion shortly after arrival. We try to get the cells into the recipient's body within 24 hours after taking them from the donor.

The survey results for 38241 were a median RVW of 3.5 and pre, intra and post services times of 30/60/30. The key reference service was CPT 99205, office or other outpatient visit for the evaluation and management of a new patient (RVW 3.17 times 7, 45, 15). In addition, the intensity/complexity measures for 38241 were either similar to or greater than those for 99205.

The ASBMT is asking for an RVW of 3.0 which is the 25th percentile of the survey. This appropriately values this service and places it in the correct rank order with the other codes in this family, 38241, 38242 and 3824x1. We also believe that this properly values 38241 with respect to the reference service, 99205, which was chosen by 24 percent of survey respondents.

An ASBMT expert panel agreed that that the median work value is too high because 38241 is a less intense service than 38240 and should be valued lower than 38240 for which an RVW of 3.5 is being requested. The intensity of an autologous stem cell infusion carries less risk in terms of the potential for adverse event in terms of infusion reactions or fluid overload (because the volume of an autologous infusion is typically lower than an allogeneic infusion).

An RVW of 3.0 places 38241 in the correct rank order with the following codes:

- 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit, has 3.86 work RVUs and times of 15/55/20
- 99233, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit, has 2.0 work RVUs and times of 10/30/15
- 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, has a work RVU of 4.5 and times of 15/40/15
- 77427, Radiation treatment management, 5 treatments, has a work RVU of 3.37 and times of 7/70/10
- 90962, End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month with a work RVU of 3.15 and 63 minutes of total time (all intra-service)
- 95953, Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended with a work RVU of 3.08 and times of 10/45/15
- 95978, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour with a work RVU of 3.5 and times of 5/60/5
- 36147, Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava) with a work RVU of 3.72 and times of 20/45/15

Specifically,

- 38241 has longer pre, intra and post times than 99205 (3.17 RVW) but is less intense
- 38241 has longer times than 99223 (3.86 RVW) (30/60/30 vs. 15/55/20) but is less intense
- 38241 is twice as long as 99233 (2.0 RVW) (30/60/30 vs. 10/30/15) and has lower intensity
- 38240 requires more time than 99291 (4.5 RVW) (30/60/30 vs. 15/40/15) but is less intense

In addition the requested RVW of 3.0 places it in the current rank order with 77427 (3.37 RVW with 70 minutes of intra-service time), 90962 (3.15 RVW and 63 minutes of intra-service time), 95953 (3.08 RVW with 45 minutes of intra-service time), 95978 (3.5 RVW with 60 minutes of intra-service time). Lastly, 36147, which is a procedure and is more intense than 38241, has an RVW of 3.72 with 45 minutes of intra-service time.

In summary, to maintain rank order, we believe that the 25th percentile accurately reflects the work performed and recommend an RVW of 3.00 for CPT 38241 with a pre-service time 30 minutes, intra-service time 60 minutes and post-service time 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is not reported using multiple CPT codes. However, an evaluation and management code is typically reported on the same say as the transplant code because these patients are usually hospitalized and are being seen every day by the transplant physician or another physician, who is also the attending physician in charge of that patient's care. For example, these patients have had their bone marrow ablated and are pancytopenic. They need to managed for their pancytopenia, infections and fluid intake. This management is entirely separate from performing a transplant. In those cases where the transplant physician is also the attending physician, that physician will report the transplant code and an evaluation and management code – usually 99232, 99233 or 99291 on the same date. On those rare occasions when a transplant is performed on an outpatient basis, no evaluation and management service is reported.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Please see answer to question 1 and the rationale.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38241

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology/Oncology How often? Commonly

Specialty Medical Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14073
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on data reported to the Center for International Blood and Marrow Transplant Research

Specialty Hematology/Oncology Frequency 10573 Percentage 75.12 %

Specialty Medical Oncology Frequency 3500 Percentage 24.87 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,394
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database Medicare Claims Data 2010

Specialty Hematology/Oncology Frequency 1045 Percentage 74.96 %

Specialty Medical Oncology Frequency 349 Percentage 25.03 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 38241

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38243 Tracking Number J3 Original Specialty Recommended RVU: **2.13**
Presented Recommended RVU: **2.13**
Global Period: XXX RUC Recommended RVU: **2.13**

CPT Descriptor: Hematopoietic progenitor cell (HPC); HPC boost

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 68-year-old who received an allogeneic (unrelated donor) transplant for AML. three months after transplant, the recipient is pancytopenic and transfusion dependednt for red cells and platelets. The blood cells are of donor origin. The remaining peripheral blood progenitor cells from the original transplant donor are infused to treat the pancytopenia.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting?

Description of Pre-Service Work: This services includes physician evaluation of the patient immediately before HPC infusion monitoring of multiple physiologic parameters and physician verification of cell processing. The physician confirms recipient and stem cell product identities, compares donor and recipient HLA typing results with previous records, acknowledges and documents ABO matching or mismatching for each respective donor unit, and reviews transplant cross-match when available. Reviews and confirms donor and recipient infectious disease testing. Confirms cell processing for either RBC or plasma depletion or mononuclear cell concentration given the donor/recipient incompatibility. The nurse, physician and cell processing technologist review cell product label, identity, sterility testing, cell dose, processing, and when the cells have been stored frozen, the DMSO contamination and precise time of washing as cells must be infused within 1 hour of washing. Signs orders for the preparatory pre-transplant medications for anaphylaxis such as epinephrine, atropine and dopamine are at bedside and immediately available if needed as well as to minimize risk of graft rejection or Graft vs. Host Disease (GVHD) with the infusion.

Description of Intra-Service Work: Supervises initiation of product infusion. Physician is present for the first 15 - 30 minutes and remains immediately available to manage toxicities and complications occurring during the infusion. The physician evaluates the patient at the end of the infusion.

Description of Post-Service Work: The physician documents the entire procedure including the pre-infusion evaluation, verification of cell processing and appropriateness for transplant, the infusion, any intra-infusion adverse events, and the post infusion evaluation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	James Gajewski & Sam Silver				
Specialty(s):	ASBMT				
CPT Code:	38243				
Sample Size:	1326	**Resp N:**	30	**Response:** 2.2 %	
Description of Sample:	ASBMT member physicians				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	25.00
Survey RVW:	1.33	2.13	**3.00**	3.97	9.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	38243	**Recommended Physician Work RVU: 2.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**0.00**	**30.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key compontents: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.43	**RUC Time**	8,436,133

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94002	XXX	1.99	**RUC Time**	17,392

CPT Descriptor 2 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

Other Reference CPT Code	Global	Work RVU	Time Source
79403	XXX	2.25	**RUC Time**

CPT Descriptor Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 38243**	**Key Reference CPT Code:** 99215	**Source of Time** **RUC Time**
Median Pre-Service Time	30.00	5.00	
Median Intra-Service Time	45.00	35.00	
Median Immediate Post-service Time	30.00	15.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**105.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.83	4.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	4.50
Urgency of medical decision making	4.83	4.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.17	4.33
Physical effort required	3.67	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.83	4.50
Outcome depends on the skill and judgment of physician	4.67	4.50
Estimated risk of malpractice suit with poor outcome	4.17	4.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.83	3.83
Intra-Service intensity/complexity	4.33	4.00
Post-Service intensity/complexity	4.00	3.83

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

38243 is a new code.
An ASBMT RVS panel reviewed and discussed the survey results for each code and then reviewed the entire family to address the issue of relativity within the family. There were 30 respondents and 83 percent of the survey respondents indicated that the vignette was typical.

The panel observed that the survey medians for the four codes were high and also did not accurately reflect their relativity. However, with the exception of 38240, the 25th percentile of the survey accurately valued the codes and their rank order. This observation of relativity within the family of codes lends credibility to the survey data - particularly the 25th percentile, except for 38240. While the median for Code 38240 is in the appropriate rank order as compared to the median values for the other codes, it is too high. On the other hand, the panel agreed that the survey 25th percentile RVW for 38240 is too low and is a clear rank order anomaly compared to the other 25th percentile values. The panel believed this was due, in part, to the low volume of respondents for this low volume procedure. In addition, physicians performing Hematopoietic Progenitor Cell (HPC) infusions typically work in academic settings and perform only a limited number of services specifically associated with HPC transplant in the Medicare population.

The panel noted that, as with 38240, 38241 and 38242, the work of the E/M performed on the same day is separate from the work of 3824x1. Even though an E/M has been performed earlier, the physician must evaluate the patient again to make sure the lymphocyte infusion can be performed. This includes chart review, an interim history, and a brief physical exam. The physician then must ensure that the cells have been properly processed, tested and handled and then must be present while the infusion is initiated and, at minimum, for the next 15-20 minutes and then must be immediately available to intervene in case of an adverse event. In this respect, the service is similar to critical care, albeit less intense. Therefore, the fact that an E/M has been performed earlier in the day, does not reduce the work of this service which is entirely different than the work of an E/M.

The survey performance rate median of 2 procedures/infusions per year among the 30 respondents is an understandable rate give this is a low volume procedure which, as indicated in the vignette, is only performed on patients having received an HPC transplant.

CPT code 38243 is new. The service was previously reported under the current code 38242. 38243 represents additional granularity and is a further clarification of the services performed within the family of HPC infusions. This code that describes an infusion of hematopoietic progenitor cells that serves as a “boost” for patients who are pancytopenic following an initial stem cell transplant. It is different from 38242 which describes lymphocyte infusions for relapse following an initial stem cell transplant. However, both services are performed on similar patient populations in that all patients have had a previous transplant and are very sick due to relapse or pancytopenia. These patients are usually hospitalized.

The panel believe that 38243 and 38242 are very similar in terms of times and intensity. This was confirmed by the survey median times of 30 minutes of pre-service, 45 minutes of intra-service, and 30 minutes of post-service time which the panel agreed accurately reflect the time required to perform this service.

The survey median RVW was 3.0 which the panel felt was too high. The key reference service was CPT 99215, office or other outpatient visit for the evaluation and management of an established patient, (RVW 2.11 with times of 5/35/15).

ASBMT believes that 99215 is an appropriate comparator code and is recommending a work RVU of 2.13 which is the survey 25th percentile. This value also places 38243 in the proper rank order with 38240, 38241 and 38242 because it is less intense than either 38240 or 38241 but very similar to 38242 which has the same times and a similar 25th percentile work RVU. Additionally, this value places it in the correct rank order with 99215, the reference service code chosen by 20 percent of survey respondents.

Aside from the key reference service, other comparator services include:

- 99233, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit, has 2.0 work RVUs and times of 10/30/15
- 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service), with an RVW of 2.25 and 30 minutes of intra-service time (it is an add-on code and has no pre or post service time
- 99357, Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service), with an RVW of 1.71 and 30 minutes of intra-service time
- 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family, has a work RVU of 2.11 and times of 5/35/15
- 70554, Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration. Which has an RVW of 2.11 and times of 15/35/10
- 79403, Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion, with an RVW of 2.25 and times of 30/30/15
- 94002, Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day, with an RVW of 1.99 and times of 15/30/15
- 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family, with an RVW of 2.43 and times of 5/30/10

With respect to these codes:

99292 has 30 minutes of intra-service time and no pre or post service time. The proposed RVW of 2.13 for 3824x1 is based on higher survey times (30/45/30) than 99292 but lower intensity.

38243 is less intense than 99233 but has the same intra-service time and substantially longer pre and post service times. Noting that 99292 is more intense than 99233, an RVW of 2.13 for 38243 places it between 99292 and 99233 which is the correct rank order. 94002 is also an appropriate comparator. It was reviewed by the RUC in 2006 with times of 15/30/15 and an RVW of 1.99. 3824x1 is more intense and has significantly longer times (30/45/30). Therefore, an RVW of 2.13 places it in the proper rank order with 94002.

79403 is an important comparator code because it involves infusion of a radiolabeled monoclonal antibody. 79403 was reviewed by the RUC in 2003. Both 38243 and 79403 involve complex infusions and patients who are very ill. Both services also involve substantial risk of complications and have similar intensity. The survey times for 38243 (30/45/30) are longer than the times for 79403 (30/30/15). Arguably, the times and RVW for 79403 support an RVW of 2.25 for 38243. However, the panel believes that the RVW recommendation should be guided by the survey results and therefore believes that an RVW of 2.13 is appropriate.

The panel also believes that 99357 is not a good comparator service because it is significantly less intense and may be reported for patients with a wide variety of illnesses. 38243 is only reported for transplant patients who have relapsed and are extremely ill. In addition, 99357 has not been reviewed since 2002 and has no pre or post service time. Most

importantly, an RVW of 2.13 places 38243 in the correct rank order with 38240 (proposed RVW of 3.5), 38241 (proposed RVW of 3.0) and 38242 (2.11).

In summary, to maintain proper rank order we believe that the 25th percentile accurately reflects the work performed and ASBMT recommend an RVW of 2.13 for 38243 with a pre-service time 30 minutes, intra-service time 45 minutes and post-service time 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is not reported using multiple CPT codes. However, an evaluation and management code is typically reported on the same say as the transplant code because these patients are usually hospitalized and are being seen every day by the transplant physician or another physician, who is also the attending physician in charge of that patient's care. For example, these patients have had their bone marrow ablated and are pancytopenic. They need to managed for their pancytopenia, infections and fluid intake. This management is entirely separate from performing a transplant. In those cases where the transplant physician is also the attending physician, that physician will report the transplant code and an evaluation and management code – usually 99232, 99233 or 99291 on the same date. On those rare occasions when a transplant is performed on an outpatient basis, no evaluation and management service is reported.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Please see answer to question 1 and the rationale.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38242

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology/Oncology How often? Commonly

Specialty Medical Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 50
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This estimate is based on a review of transplant data reported to the Center for International Blood and Marrow Transplant Research (CIBMTR)

Specialty Hematology/Oncology Frequency 38 Percentage 76.00 %

Specialty Medical Oncology Frequency 12 Percentage 24.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on RUC database Medicare Claims Data for Code 38240 wich represents roughly 5% of total total estimated number of allogeneic transplants reported by the CIBMTR. 5% of of the total estimated number of HPC boosts is 3.

Specialty Hematology/Oncology Frequency 2 Percentage 66.66 %

Specialty Medical Oncology Frequency 1 Percentage 33.33 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 38242

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38242 Tracking Number J4 Original Specialty Recommended RVU: **2.11**
Presented Recommended RVU: **2.11**
Global Period: XXX RUC Recommended RVU: **2.11**

CPT Descriptor: Hematopoietic progenitor cell (HPC); allogeneic lymphocyte infusion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 67-year-old who had a prior allogeneic transplant for B cell chronic lymphocytic leukemia. She has recently relapsed. Her T cell lymphocytes are 50% donor and 50% host. A T lymphocyte infusion using lymphocytes from the original donor is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting?

Description of Pre-Service Work: This services includes physician evaluation of the patient immediately before HPC infusion monitoring of multiple physiologic parameters and physician verification of cell processing. The physician confirms recipient and stem cell product identities, compares donor and recipient HLA typing results with previous records, acknowledges and documents ABO matching or mismatching for each respective donor unit, and reviews transplant cross-match when available. Reviews and confirms donor and recipient infectious disease testing. Confirms cell processing for either RBC or plasma depletion or mononuclear cell concentration given the donor/recipient incompatibility. The nurse, physician and cell processing technologist review cell product label, identity, sterility testing, cell dose, processing, and when the cells have been stored frozen, the DMSO contamination and precise time of washing as cells must be infused within 1 hour of washing. Signs orders for the preparatory pre-transplant medications for anaphylaxis such as epinephrine, atropine and dopamine are at bedside and immediately available if needed as well as to minimize risk of graft rejection or Graft vs. Host Disease (GVHD) with the infusion.

Description of Intra-Service Work: Supervises initiation of product infusion. Physician is present for the first 15 - 30 minutes and remains immediately available to manage toxicities and complications occurring during the infusion. The physician evaluates the patient at the end of the infusion.

Description of Post-Service Work: The physician documents the entire procedure including the pre-infusion evaluation, verification of cell processing and appropriateness for transplant, the infusion, any intra-infusion adverse events, and the post infusion evaluation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	James Gajewski & Sam Silver				
Specialty(s):	ASBMT				
CPT Code:	38242				
Sample Size:	1326	**Resp N:**	31	**Response:** 2.3 %	
Description of Sample:	ASBMT member physicians				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.50	**5.00**	10.00	15.00
Survey RVW:	0.81	2.11	**2.75**	3.73	7.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	22.50	**45.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	38242	**Recommended Physician Work RVU: 2.11**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**0.00**	**30.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.17	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key compontents: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.41	**RUC Time**	8,436,133

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94002	XXX	1.99	**RUC Time**	17,392

CPT Descriptor 2 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

Other Reference CPT Code	Global	Work RVU	Time Source
79403	XXX	2.25	**RUC Time**

CPT Descriptor Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 16.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 38242**	**Key Reference CPT Code:** 99205	**Source of Time** **RUC Time**
Median Pre-Service Time	30.00	7.00	
Median Intra-Service Time	45.00	45.00	
Median Immediate Post-service Time	30.00	15.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**105.00**	**67.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	5.00	4.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	4.40
Urgency of medical decision making	4.40	3.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.80
Physical effort required	3.40	3.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	4.40
Outcome depends on the skill and judgment of physician	4.60	4.00
Estimated risk of malpractice suit with poor outcome	4.20	3.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	5.00	4.40
Intra-Service intensity/complexity	4.00	3.60
Post-Service intensity/complexity	4.20	4.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An ASBMT RVS panel reviewed and discussed the survey results for each code and then reviewed the entire family to address the issue of relativity within the family. There were 31 respondents and 87 percent of the survey respondents indicated that the vignette was typical.

The panel observed that the survey medians for the four codes were high and also did not accurately reflect their relativity. However, with the exception of 38240, the 25th percentile of the survey accurately valued the codes and their rank order. This observation of relativity within the family of codes lends credibility to the survey data - particularly the 25th percentile, except for 38240. While the median for Code 38240 is in the appropriate rank order as compared to the median values for the other codes, it is too high. On the other hand, the panel agreed that the survey 25th percentile RVW for 38240 is too low and is a clear rank order anomaly compared to the other 25th percentile values. The panel believed this was due, in part, to the low volume of respondents for this low volume procedure. In addition, physicians performing Hematopoietic Progenitor Cell (HPC) infusions typically work in academic settings and perform only a limited number of services specifically associated with HPC transplant in the Medicare population.

This code was resurveyed because it is part of the family that includes 38240, 38241 and 3824x1.

Compelling Evidence for RVW Increase:
Codes 38240 and 38241 currently have a CMS/other value of 2.24 as well as 53 minutes of assigned total time. We are recommending RVW increases in both codes. In addition 38242 was reviewed by the RUC in 2002 and has an RVW of 1.71 with physician time of 30/30/20 and we are recommending an RVW increase for this procedure as well.

With respect to 38240 and 38241, it is important to note that these codes have never had a vignette, a service description, or been surveyed or reviewed by the RUC. The work values are based upon an assigned time of 53 total minutes (which have never been RUC approved either). In our view this code has never been properly valued and we request that the RUC review this code as if it was a new code.

Furthermore, the patient population receiving allogeneic and autologous transplants has changed over the last 10-15 years and is now comprised largely of older patients with leukemia, myeloma and other hematologic malignancies who are in serious or critical condition because they have just received ablative chemotherapy completely wiping out their bone marrow.

The typical patient has changed significantly since the valuation of these codes (1995 for 38240 and 38241; 2002 for 38242). Allogeneic patients prior to 1995 almost always received HLA identical sibling transplants. The recipients were also primarily younger recipients, as the maximum recipient age at that point in time was age 40-45. We now will routinely do transplants on recipients aged 65-80, whether autologous or allogeneic. On the day of transplant, these patients are being actively managed for complications of the chemotherapy and radiation therapy regimens administered on prior days, such as dehydration and electrolyte imbalances as well as for infection management which is a consequence of the pancytopenia and the underlying leukemia, lymphoma or myeloma malignancy for which they are having the transplant. The allogeneic transplant recipients for code 38240 and 3824x1 are already on immunosuppressive drug therapy which routinely causes electrolyte deficiency, hypertension, and the need for antibiotics for infection management. Additionally, these older patients have co-morbidities such as heart disease and diabetes. Post infusion documentation of the infusion report has increased in complexity due to increasing regulatory reporting requirements. The transplant infusion is the source documentation for this regulatory reporting.

At the time of the 1995 valuation, the unrelated donor registry was very small (approx. 30,000-50,000 donors). It was the rare patient that had an unrelated donor match. Public umbilical cord blood banking for the purposes of allogeneic transplant did not exist. Now, approximately 60% of transplants are from unrelated donors or cord blood donors, with the remainder from HLA identical siblings. We are also seeing a rise in haplo-identical, half-matched relative transplants. With mismatched transplants, we have the additional issues of graft rejection and ABO incompatibility between donor(s) and recipient. Both of these create increased potential for acute toxicity. We also have a greater potential for minor red cell antigen mismatching causing acute febrile reactions. Additionally, as most donors are

harvested with peripheral blood stem cell harvest, we also have increased risk of TRALI, an acute white cell reaction causing acute pulmonary decompensation.

These same clinical issues apply for 38242 which is a subsequent infusion of donor lymphocytes to previously transplanted patients for the treatment of relapse after transplantation for a myeloproliferative disorder.

With the changes in technology and patient population, the current RVWs do not adequately describe the physician work effort for any of these procedures. The physician must now be present to identify the recipient and donor, to review donor/recipient HLA typing, review and make sure the correct cell processing has occurred and review infectious disease status in the donor and recipient. A physician is usually at the bedside for the initial 15 minutes to half hour of the infusion and then every five to fifteen minutes thereafter and is immediately available during the entire infusion to manage complications should they occur. Complications can occur during infusion or well after the infusion. Fluid management is now much more important due to the higher volumes of cells being infused (especially during unrelated donor transplants) which results in a higher risk of fluid overload and congestive heart failure in these older patients. For this reason, the typical time for the infusion has increased. Almost all of these patients are on continuous EKG, blood pressure and pulse oximetry monitoring during the infusion. Post infusion documentation has increased in complexity due to more burdensome regulatory reporting requirements. The transplant infusion is the source documentation for this regulatory reporting.

In addition, the consent process has changed considerably since these codes were developed because of the changes in recipients, donors and risks of the transplantation process. Unrelated donors cannot be forced to donate and can back out immediately before transplant. As this leaves the recipient in a precarious state, the infusion consent process requires a lengthy discussion of risks. The use of unrelated donor cells usually means the cells are harvested elsewhere and transported to the center in which the recipient is admitted. Due to the use of fresh cells for infusion, the cells frequently arrive in the evening or in the middle of the night, necessitating an infusion shortly after arrival. We try to get the cells into the recipient's body within 24 hours after taking them from the donor.
The panel noted that, as with 38240 and 38241, the work of the E/M performed on the same day is separate from the work of 38242. Even though an E/M has been performed earlier, the physician must evaluate the patient again to make sure the lymphocyte infusion can be performed. This includes chart review, an interim history, and a brief physical exam. The physician then must ensure that the lymphocytes have been properly processed, tested and handled and then must be present while the infusion is initiated and, at minimum, for the next 15-20 minutes and then must be immediately available to intervene in case of an adverse event. In this respect, the service is similar to critical care, albeit less intense. Therefore, the fact that an E/M has been performed earlier in the day, does not reduce the work of this service which is entirely different than the work of an E/M.

There were 31 respondents to the survey request and 89% thought the vignette was typical. Physicians performing Hematopoietic Progenitor Cell (HPC) infusions typically work in academic settings and perform only a limited number of services specifically associated with HPC transplant. They do not regularly receive survey requests and are therefore, less likely to complete surveys. Therefore, the low number of respondents was expected. Further, this procedure is lower volume than 38240 and 38241 so the survey performance rate median of 5 procedures/infusions per year among the 31 respondents is an understandable rate. This procedure is only performed on patients having previously received an allogeneic HPC transplant.

The current CPT code 38242 was last reviewed by the RUC in 2002 and currently has an RVW of 1.71 with pre, intra and post services times of 30/30/20.

After review of the results of this survey, the ASBMT panel agreed that the survey median time of 30 minutes of pre-service, 45 minutes of intra-service, and 30 minutes of post-service time accurately reflect the time required to perform this service.

The median survey RVW was 2.75. The key reference service was CPT 99205, office or other outpatient visit for the evaluation and management of a new patient which has a work RVU of 3.17 and times of 7/45/15. The panel thought that 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity, was a more comparable service because it has a work RVU of 2.11 and times of

5/35/15. The panel believed that 38242 should be valued similarly to 99215 because it is a little less intense than 99215 but has substantially longer pre and post service times.

Therefore, ASBMT is recommending an RVW of 2.11 which is the survey 25th percentile. This value also places it in correct rank order with 38240 or 38241 because it is less intense and requires less time than those procedures. It also places 38242 in the correct rank order to 3824x1 because it has similar intensity and pre/intra/post service times to 3824x1.

Even though the panel did not believe 99205 was the best reference code, an RVW of 2.11 properly ranks 38242 with the reference code, 99205 which was chosen by 16 percent of survey respondents. 99205 has more intra-service time and is more complex and intense than 38242.

Aside from the key reference service, other comparator services include:

- 99233, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit, has 2.0 work RVUs and times of 10/30/15
- 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service), with an RVW of 2.25 and 30 minutes of intra-service time (it is an add-on code and has no pre or post service time
- 99357, Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service), with an RVW of 1.71 and 30 minutes of intra-service time
- 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family, has a work RVU of 2.11 and times of 5/35/15
- 70554, Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration. Which has an RVW of 2.11 and times of 15/35/10
- 79403, Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion, with an RVW of 2.25 and times of 30/30/15
- 94002, Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day, with an RVW of 1.99 and times of 15/30/15
- 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family, with an RVW of 2.43 and times of 5/30/10

When the RUC valued this code in 2002, it used 99292 and 99357 as the two main comparator codes. At that time the RUC thought that 38242 was less intense than 99292 and had similar times and intensity to 99357. In addition, the RUC thought that an RVW of 1.71 placed 38242 in the correct rank order to 38240 which had a value of 2.24.

What has changed? Since 2002, the value of 99292 has increased and the intensity of 38242 has increased due to the older, sicker patient population. 99292 has 30 minutes of intra-service time and no pre or post service time. The current proposed RVW of 2.11 for 38242 is also based on higher survey times (30/45/30 as compared to 30/30/20 in 2002). The panel also believes that 99357 is not a good comparator service because it is significantly less intense and

may be reported for patients with a wide variety of illnesses. 38242 is only reported for transplant patients who have relapsed and are extremely ill. In addition, 99357 has not been reviewed since 2002 and has no pre or post service time. Most importantly, an RVW of 2.11 places 38242 in the correct rank order with 38240 (proposed RVW of 3.5) and 38241 (proposed RVW of 3.0).

With respect to the other codes listed above, 38242 is less intense than 99233 but has the same intra-service time and substantially longer pre and post service times. Noting that 99292 is more intense than 99233, an RVW of 2.11 for 38242 places it between 99292 and 99233 which is the correct rank order. 94002 is also an appropriate comparator. It was reviewed by the RUC in 2006 with times of 15/30/15 and an RVW of 1.99. 38242 is more intense and has significantly longer times (30/45/30). Therefore, an RVW of 2.11 places it in the proper rank order with 94002.

79403 is an important comparator code because it involves infusion of a radiolabeled monoclonal antibody. 79403 was reviewed by the RUC in 2003, after 38242 was reviewed in 2002. Both codes involve complex infusions and patients who are very ill. Both services also involve substantial risk of complications and have similar intensity. The survey times for 38242 (30/45/30) are longer than the times for 79403 (30/30/15). Arguably, the times and RVW for 79403 support an RVW of 2.25 for 38242. However, the panel believes that the RVW recommendation should be guided by the survey results and therefore believes that an RVW of 2.11 is appropriate.

In summary, to maintain rank order we believe that the 25th percentile accurately reflects the work performed and recommend an RVW of 2.11 for 38242 with a pre-service time 30 minutes, intra-service time 45 minutes and post-service time 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is not reported using multiple CPT codes. However, an evaluation and management code is typically reported on the same say as the transplant code because these patients are usually hospitalized and are being seen every day by the transplant physician or another physician, who is also the attending physician in charge of that patient's care. For example, these patients have had their bone marrow ablated and are pancytopenic. They need to managed for their pancytopenia, infections and fluid intake. This management is entirely separate from performing a transplant. In those cases where the transplant physician is also the attending physician, that physician will report the transplant code and an evaluation and management code – usually 99232, 99233 or 99291 on the same date. On those rare occasions when a transplant is performed on an outpatient basis, no evaluation and management service is reported.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Please see answer to question 1 and the rationale.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38242

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology/Oncology How often? Commonly

Specialty Medical Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 553
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on data reported to the Center for International Blood and Marrow Transplant Research

Specialty Hematology/Oncology Frequency 413 Percentage 74.68 %

Specialty Medical Oncology Frequency 140 Percentage 25.31 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 66 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database Medicare Claims Data 2010

Specialty Hematology/Oncology Frequency 50 Percentage 75.75 %

Specialty Medical Oncology Frequency 16 Percentage 24.24 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 38242

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Bone Marrow Stem Cell Transplant

TAB: 16

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99205	Office or other outpatient visit for the evaluation and management of a new patient,	8	0.059			3.17			67	7					45			15
CURRENT	38240	Bone marrow or Blood-derived peripheral stem cell transplantation; allogeneic		0.042			2.24			53						53			
SVY	38240	Hematopoietic progenitor ell (HPC); allogeneneic transplantation per donor	37	0.044	1.00	2.47	4.00	4.00	11.00	120	30			10	40	60	70	360	30
REC	38240	Hematopoietic progenitor ell (HPC); allogeneneic transplantation per donor		0.044			4.00			120	30					60			30

ISSUE: Bone Marrow Stem Cell Transplant

TAB: 16

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99205	Office or other outpatient visit for the evaluation and management of a new patient,	8	0.059			3.17			67	7					45			15
CURRENT	38241	Bone marrow or Blood-derived peripheral stem cell transplantation; autologous		0.042			2.24			53						53			
SVY	38241	Hematopoietic progenitor cell (HPC); autologous transplantation	33	0.036	0.97	3.00	3.50	4.00	11.00	120	30			10	30	60	60	240	30
REC	38241	Hematopoietic progenitor cell (HPC); autologous transplantation		0.032			3.00			108	18					60			30

SS Rec Summary

ISSUE: Bone Marrow Stem Cell Transplant

TAB: 16

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99215	Office or other outpatient visit for the evaluation and management of an established	6	0.047			2.11			55	5					35			15
	38243			#DIV/0!						0									
SVY	38243	Hematopoietic progenitor cell (HPC); HPC boost	30	0.037	1.33	2.13	3.00	3.97	9.00	105	30			0	30	45	60	120	30
REC	38243	Hematopoietic progenitor cell (HPC); HPC boost		0.017			2.13			105	30					45			30

ISSUE: Bone Marrow Stem Cell Transplant

TAB: 16

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99205	Office or other outpatient visit for the evaluation and management of a new patient,	5	0.059			3.17			67	7					45			15
CURRENT	38242	Bone marrow or Blood-derived peripheral stem cell transplantation; allogeneic donor		0.020			1.71			80	30					30			20
SVY	38242	Hematopoietic progenitor cell (HPC); allogeneic lymphocyte infusion	31	0.031	0.81	2.11	2.75	3.73	7.00	105	30			10	23	45	60	120	30
REC	38242	Hematopoietic progenitor cell (HPC); allogeneic lymphocyte infusion		0.017			2.11			105	30					45			30

AMA/Specialty Society RVS Update Committee Summary of Recommendations
MPC List / CMS High Expenditure Procedural Codes

April 2012

Optical Endomicroscopy

In the 2012 Medicare Physician Fee Schedule (MFS) Final Rule the Centers for Medicare and Medicaid Services (CMS) requested that the RUC review CPT codes 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure*). At the February 2012 CPT Editorial Panel meeting, the specialty societies presented two new endoscopic procedures for optical endomicroscopy: 43206 *Esophagoscopy, rigid or flexible; with optical endomicroscopy; and* 43252 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy;* as well as one new pathology procedure for optical endomicroscopy: 88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session.* In the final rule, CMS stated that if new codes are introduced within a family, the entire family should be reviewed in order to maintain relativity and avoid separate valuations of codes within a specific family. Because the existing family of codes were already scheduled for review at either the October 2012 or January 2013 RUC meetings, the RUC agrees with the specialty societies that survey and review of the family of codes should be delayed in order to maintain relativity and meet CMS standards. **The RUC recommends that the specialty societies survey 43206 and the esophagoscopy family of codes for review at the October 2012 RUC meeting, and CPT codes 43252 and 88375 with the Upper Gastrointestinal Endoscopy Codes for review at the January 2013 RUC meeting. In the interim the RUC recommends that CPT codes 43206, 43252 and 88375 be carrier priced for 2013.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery				
Digestive System				
Endoscopy				
For endoscopic procedures, code appropriate endoscopy of each anatomic site examined.				
Surgical endoscopy always includes diagnostic endoscopy				

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⊙43200	NN1	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	October 2012 RUC Meeting
⊙43206	NN2	with optical endomicroscopy (Report supply of contrast agent separately) (Do not report 43206 in conjunction with 88375)	000	Carrier Price Review at October 2012 RUC Meeting
⊙43201	NN3	with directed submucosal injection(s), any substance (For injection schlerosis of espohageal varices, use 43204)	000	October 2012 RUC Meeting
⊙43202	NN4	with biopsy, single or multiple	000	October 2012 RUC Meeting
⊙43204	NN5	with injection sclerosis of esophageal varices	000	October 2012 RUC Meeting
⊙43205	NN6	with band ligation of esophageal varices	000	October 2012 RUC Meeting
⊙43215	NN7	with removal of foreign body (For radiological supervision and interpretation, use 74235)	000	October 2012 RUC Meeting
⊙43216	NN8	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	000	October 2012 RUC Meeting
⊙43217	NN9	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	000	October 2012 RUC Meeting

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⊙43219	NN10	with insertion of plastic tube or stent	000	October 2012 RUC Meeting
⊙43220	NN11	with balloon dilation (less than 30 mm diameter) (If imaging guidance is performed, use 74360) (For endoscopic dilation with balloon 30 mm diameter or larger, use 43458) (For dilation without visualization, use 43450-43453) (For diagnostic fiberoptic esophagogastroscopy, use 43200, 43235) (For fiberoptic esophagogastroscopy with biopsy or collection of specimen, use 43200, 43202, 43235, 43239) (For fiberoptic esophagogastroscopy with removal of foreign body, use 43215, 43247) (For fiberoptic esophagogastroscopy with removal of polyp(s), use 43217, 43251)	000	October 2012 RUC Meeting
⊙43226	NN12	with insertion of guide wire followed by dilation over guide wire (For radiological supervision and interpretation, use 74360)	000	October 2012 RUC Meeting
⊙43227	NN13	with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	000	October 2012 RUC Meeting
⊙43228	NN14	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (For esophagoscopic photodynamic therapy, report 43228 in addition to 96570, 96571 as appropriate)	000	October 2012 RUC Meeting
⊙43231	NN15	with endoscopic ultrasound examination (Do not report 43221 in conjunction with 76975)	000	October 2012 RUC Meeting

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⊙43232	NN16	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (Do not report 43232 in conjunction with 76942, 76975) (For interpretation of specimen, see 88172-88173)	000	October 2012 RUC Meeting
D⊙43234		~~Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)~~	000	N/A
⊙43235	NN17	Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	January 2013 RUC Meeting
⊙●43252	NN18	with optical endomicroscopy (Report supply of contrast agent separately) (Do not report 43252 in conjunction with 88375)	000	Carrier Price Review at January 2013 RUC Meeting
⊙43236	NN19	with directed submucosal injection(s), any substance (For injection schlerosis of esophageal and/or gastric varices, use 43243	000	January 2013 RUC Meeting
⊙43237	NN20	with endoscopic ultrasound examination limited to the esophagus (Do not report 43237 in conjunction with 76942, 76975)	000	January 2013 RUC Meeting
⊙43238	NN21	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus) (Do not report 43238 in conjunction with 76942 or 76975)	000	January 2013 RUC Meeting

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⊙43239	NN22	with biopsy, single or multiple	000	January 2013 RUC Meeting
⊙43240	NN23	with transmural drainage of pseudocyst	000	January 2013 RUC Meeting
⊙43241	NN24	with transendoscopic intraluminal tube or catheter placement	000	January 2013 RUC Meeting
⊙43242	NN25	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate) (Do not report 43242 in conjunction with 76942, 76975) (For transendoscopic fine needle aspiration/biopsy limited to esophagus, use 43238) (For interpretation of specimen, see 88172-88173)	000	January 2013 RUC Meeting
⊙43243	NN26	with injection sclerosis of esophageal and/or gastric varices	000	January 2013 RUC Meeting
⊙43244	NN27	with band ligation of esophageal and/or gastric varices	000	January 2013 RUC Meeting
⊙43245	NN28	with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie) (Do not report 43245 in conjunction with 43256)	000	January 2013 RUC Meeting

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⊙43246	NN29	with directed placement of percutaneous gastrostomy tube (For nonendoscopic percutaneous placement of gastrostomy tube, see 49440)	000	January 2013 RUC Meeting
⊙43247	NN30	with removal of foreign body (For radiological supervision and interpretation, use 74235)	000	January 2013 RUC Meeting
⊙43248	NN31	with insertion of guide wire followed by dilation of esophagus over guide wire	000	January 2013 RUC Meeting
⊙43249	NN32	with balloon dilation of esophagus (less than 30 mm diameter)	000	January 2013 RUC Meeting
⊙43250	NN33	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	000	January 2013 RUC Meeting
⊙43251	NN34	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	000	January 2013 RUC Meeting
⊙43255	NN35	with control of bleeding, any method	000	January 2013 RUC Meeting
⊙43256	NN36	with transendoscopic stent placement (includes predilation)	000	January 2013 RUC Meeting
⊙43257	NN37	with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	000	January 2013 RUC Meeting

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⊙43258	NN38	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (For injection schlerosis of espophageal varices, use 43204, 43243)	000	January 2013 RUC Meeting
⊙43259		with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate (Do not report 43259 in conjunction with 76975)	000	January 2013 RUC Meeting
Pathology and Laboratory **Surgical Pathology**				
●88375	NN39	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session (Do not report 88375 in conjunction with 43206 or 43252) (For biopsy specimen pathology use 88305)	XXX	Carrier Price Review at January 2013 RUC Meeting

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February 17, 2012

Barbara Levy, MD
Chair, AMA / Specialty Society Relative Value Update Committee
515 N. State St.
Chicago, IL 60657

Dear Dr. Levy,

The American Gastroenterological Association, (AGA), American College of Gastroenterology (ACG) and American Society for Gastrointestinal Endoscopy have proposed an action plan to systematically review and survey gastrointestinal endoscopic services. This is in response to a request made by the Centers for Medicare and Medicaid Services (CMS) in the 2012 Medicare Physician Fee Schedule (MPFS) Final Rule to survey codes 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure*). In the Final Rule, CMS has stated that if new codes are introduced within a family, the entire family should be reviewed to maintain relativity and avoid separate valuations of codes within a specific family. This action plan was reviewed and accepted by the RUC at its January 2012 meeting.

At the February 2012 CPT Editorial Panel meeting, the GI societies presented a coding change application for two endoscopic procedures for optical endomicroscopy:

- *4321X1; Esophagoscopy, rigid or flexible; with optical endomicroscopy*
- *4321X2; Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy*

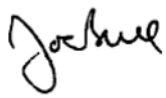
The RUC's LOI packet dated February 7, 2012 requests survey of these procedures.

We request that the RUC communicate to CMS that codes 4321X1 and 4321X2 should be carrier priced for 2013. We propose to survey code 4321X1 with codes 43200-43232 and present the esophagoscopy family of codes to the RUC at the October 2012 meeting. We propose to

survey code 4321X2 with codes 43235-43259 and present the esophagogastroduodenoscopy family of codes to the RUC at the January 2013 meeting.

We appreciate your consideration of this request. If you have any additional questions please contact Adam Borden, AGA, 301-941-2629 or aborden@gastro.org; Samuel Reynolds, ASGE, 630-570-5643 or sreynolds@asge.org; or Brad Conway, ACG, 301-263-9000 or bconway@gi.org.

Sincerely,



Joel V. Brill, MD
AGA RUC Advisor



Nicholas Nickl, MD
ASGE RUC Advisor



Daniel DeMarco, MD
ACG CPT Advisor

April 3, 2012

Barbara Levy, MD
Chair, AMA / Specialty Society Relative Value Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60657

Dear Doctor Levy,

The College of American Pathologists (CAP) recommends that new CPT code 88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session* be carrier priced for 2013. In February 2012, the American Gastroenterological Association, (AGA), American College of Gastroenterology (ACG) and American Society for Gastrointestinal Endoscopy assisted the AMA CPT Editorial Panel in the creation of the following three new optical endomicroscopy-related CPT codes.

43206; *Esophagoscopy, rigid or flexible; with optical endomicroscopy*
(Report supply of contrast agent separately)
(Do not report 43206 in conjunction with 88375)

43252; *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy*
(Report supply of contrast agent separately)
(Do not report 43252 in conjunction with 88375)

88375; *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session*
(Do not report 88375 in conjunction with 43206 or 43252)
(For biopsy specimen pathology use 88305)

Since that time, the AGA, ACG, and the ASGE undertook a proposal to systematically review and survey all gastrointestinal endoscopic services. This action plan introduced by the gastroenterology societies was reviewed and accepted by the RUC at its January 2012 meeting. This is in response to a request made by the Centers for Medicare and Medicaid Services (CMS) in the 2012 Medicare Physician Fee Schedule Final Rule to survey codes 43235 *Upper gastrointestinal endoscopy including esophagus,*

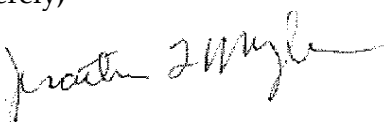
stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure*). In the Final Rule, CMS has stated that if new codes are introduced within a family, the entire family should be reviewed to maintain relativity and avoid separate valuations of codes within a specific family.

CAP initially indicated on the RUC's LOI that we would survey pathology code 88375 for presentation at the April 2012 RUC meeting. Subsequently, CAP learned of the GI society's action plans and their intentions to postpone surveying for 43206 and 43252, until they had a chance to survey their families of endoscopy codes in response to CMS' request. Because of the relationship between the 43206 and 43252 codes and the pathology service, CAP believes that it is necessary to survey and present recommendations for code 88375 at the same time as the 43206-43252 codes are presented to the RUC. This would also be more consistent with the RUC's and CMS' established policy of reviewing codes. CAP then alerted AMA staff of our intentions to follow the GI society's lead in recommending that all three codes be carrier priced for 2013, and to survey for code 88375 for presentation at the January 2013 RUC meeting.

We request that the RUC communicate to CMS that code 88375 should be carrier priced for 2013. We propose to survey code 88375 and present physician work and practice expense to the RUC at the January 2013 meeting.

We appreciate your consideration of this request. If you have any additional questions please contact Todd Klemp, Associate Director of Economic Affairs and Regulatory at 847-832-7403 or tklemp@cap.org

Sincerely,



Jonathan L. Myles, MD, FCAP
Chair, Economic Affairs Committee

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Fecal Bacteriotherapy

In February 2012, the CPT Editorial Panel created CPT code 44705 *Preparation of fecal microbiota for instillation, including assessment of donor specimen*. The specialty societies conducted a survey of this rarely performed service and only received responses from 11 physicians whom perform the service described. The RUC agreed with the specialty societies that the survey respondents overestimated the physician work involved. The RUC reviewed the results of an expert panel of physicians as presented to the RUC and determined that a work RVU of 1.42, below the 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey time of 4 minutes pre-service, 20 minutes intra-service and 5 minutes post-service. This service is delivered to the donor and is primarily oriented to establish that the donor is a well patient and suitable to act as a donor. The work is equivalent to a 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42). The RUC compared 44705 to 99203 and determined both services require the same physician work and physician time to perform. The RUC determined a direct crosswalk to CPT code 99203 is appropriate. **The RUC recommends a work RVU of 1.42 for CPT code 44705, a direct crosswalk to CPT code 99203.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Digestive System** **Other Procedures**				
●44705	X1	Preparation of fecal microbiota for instillation, including assessment of donor specimen (Do not report 44705 in conjunction with 74283) (For fecal instillation by oro-nasogastric tube or enema, use 44799)	XXX	1.42

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:44705 Tracking Number X1 Original Specialty Recommended RVU: **1.42**
Presented Recommended RVU: **1.42**
Global Period: XXX RUC Recommended RVU: **1.42**

CPT Descriptor: Preparation of fecal microbiota for instillation, including assessment of donor specimen
(Do not report 44705 in conjunction with 74283)
(For fecal instillation by oro-nasogastric tube or enema, use 44799)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old female with refractory, relapsing C. difficile diarrhea despite multiple courses of antibiotic treatment, is referred for evaluation and consideration of treatment options. After assessment (reported separately as E/M) it is elected to utilize fecal microbiota therapy. The physician has selected the potential donor and oversees evaluation and preparation of the specimen.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 45%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician reviews the medical history form completed by the potential donor as well as any available donor health records. The physician reviews the FDA protocol-delineated laboratory tests to determine whether the patient is a suitable candidate for being a fecal donor and if there are contraindications to the stool donation.

Description of Intra-Service Work: The physician conducts a detailed review of the donor's past medical and surgical history and current health status pertaining to recent antibiotic use, travel, immunodeficiency disease, and related issues. The physician reviews the donor's medication list to determine if the patient has used medications that are contraindicated for a trans-faunal donation. The physician conducts a focused physical examination for conditions which may contraindicate donation. The physician reviews the laboratory tests with the donor. The physician makes a final determination of whether the donor is suitable. In the event that pathological conditions are identified by history, physical exam, or laboratory testing, the physician arranges referral of the donor to their primary health care provider(s) or emergency evaluation if appropriate.

Following collection of the fecal specimen, the physician oversees the preparation of the filtered material to be infused into the recipient. A time out relative to the infusion specimen is performed.

Description of Post-Service Work: The physician completes documentation of the donor suitability. The physician is available to answer any questions from the donor patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Lawrence Martinelli, MD (IDSA); Johan Bakken, MD (IDSA); Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE)		
Specialty(s):	Infectious Diseases (IDSA), Gastroenterology (ASGE, AGA)		
CPT Code:	44705		
Sample Size:	177	**Resp N:** 11	**Response:** 6.2 %
Description of Sample:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	5.50	**10.00**	18.50	33.00
Survey RVW:	0.75	1.63	**2.50**	3.28	4.50
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	27.50	**50.00**	60.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	44705	**Recommended Physician Work RVU: 1.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**4.00**	**0.00**	**4.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.43	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	3,074,347

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92004	XXX	1.82	**RUC Time**	2,123,579

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Other Reference CPT Code	Global	Work RVU	Time Source
99203	XXX	1.42	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 36.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 44705**	**Key Reference CPT Code:** 99204	**Source of Time RUC Time**
Median Pre-Service Time	4.00	5.00	

Median Intra-Service Time	20.00	30.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**29.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.25
Urgency of medical decision making	3.75	3.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.50
Physical effort required	3.50	2.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	3.80
Outcome depends on the skill and judgment of physician	3.75	4.00
Estimated risk of malpractice suit with poor outcome	4.25	3.75

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.75	3.00
Intra-Service intensity/complexity	3.50	4.00
Post-Service intensity/complexity	2.50	2.75

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Infectious Diseases Society of America (IDSA), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of 177 physicians who perform the service described by CPT code 44705*; Preparation of fecal microbiota for instillation, including assessment of donor specimen.* We received 18 responses but only 11 responses (6.2 percent) were from physicians familiar with the procedure and the physician work and practice expense involved in performing this service.

A panel of physician reviewers from the surveying societies found the survey data to be flawed for the following reasons:

1) A low response rate (N < 30) to the survey
2) Even with low numbers, 7 respondents reported a zero performance rate for the service, meaning that they had not previously performed the procedure. These responses were eliminated for purposes of analysis reducing the number of responses from N = 18 to the current N = 11.
3) Possibly because this is a rarely performed service, respondents appeared to not understand the elements involved in the procedure that were separate from other associated services resulting in high survey recommendations regarding physician work.

In view of the flawed survey data resulting in values that appeared to be inflated, an expert physician panel was convened by the specialty societies to review the survey results and make recommendations regarding 44705. The panel considered possible reasons that the survey respondents may have misunderstood the survey questions. They noted that while the CPT text descriptor is: "preparation of fecal microbiota for instillation, including assessment of donor specimen," (i.e. work related to the donor specimen), the first two sentences of the three-sentence vignette describes the recipient patient. The panel concluded that this may have misled survey respondents to include work related to the management of the recipient in their work estimates rather than confining their work estimates to those related to specimen preparation.

The key reference code identified in the survey was 99204; *Office or other outpatient visit for the evaluation and management of a new patient*, RVW = 2.43, physician times (5 / 30 / 10). The expert panel did believe this reference code describes a service with a number of similarities in physician work to the surveyed code but believed that 99204 likely describes a greater amount of work than that inherent to this code. In reviewing the pre-, intra-, and post-service work descriptors, the panel determined that this work essentially constituted a new outpatient standard evaluation and management service delivered to the donor, and primarily oriented to establish that the donor is a well patient and suitable to act as a donor. The panel determined that the chosen key reference service, 99204, constituted greater work than would be attributed to such a well patient evaluation (possibly again related to survey respondent inclusion of work services delivered to the recipient patient), and felt that 99203 with RVW = 1.42 and physician times (4 / 20 / 5), more accurately represents the actual work amount in both time and RVW value for this service.

Therefore, the societies recommend that 44705 be cross-walked to code 99203 recommending an RVW value 1.42 and physician times (4 / 20 / 5). This recommendation is significantly lower than the 25th percentile from the limited survey data reported at RVW = 1.63 with intra - service time 27.5 minutes. Further, the recommendation for 44705 results in an IWPUT of 0.0598 which is comparable to the IWPUT for the Key Reference Service code 99204 (IWPUT = 0.0697), the comparison codes from the MPC list 99202 (IWPUT = 0.0516) and 92004 (IWPUT = 0.0594), and the crosswalk code 99203 (IWPUT = 0.0609).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 44799; unlisted procedure, intestine

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Infectious Diseases How often? Rarely

Specialty Gastroenterology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on estimates of the specialty physicians who perform this procedure, we believe that approximately 40% of claims will be reported by infectious diseases physicians and 60% by gastroenterologists.

Specialty Infectious Diseases Frequency 400 Percentage 40.00 %

Specialty Gastroenterology Frequency 600 Percentage 60.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe this procedure is performed in the Medicare-eligible population approximately 70% of the time.

Specialty Infectious Diseases Frequency 280 Percentage 40.00 %

Specialty Gastroenterology Frequency 420 Percentage 60.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 91065

SS Rec Summary

ISSUE: Fecal Bacteriotherapy - 44705

TAB: 18

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99204	Office or othe	NA	0.070			2.43			45	5					30			10
REF 2	99203	Office or othe	NA	0.061			1.42				4					20			5
SVY	44705	Preparation of fecal	11	0.030	0.75	1.63	2.50	3.28	4.50	95	30			10	28	50	60	90	15
REC	44705	Preparation of fecal	11	0.061			1.42			29	4					20			5

CPT Code:__44705_
Specialty Society('s)_IDSA, AGA, ASGE_

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

Preparation of fecal microbiota for instillation, including assessment of donor specimen
(Do not report 44705 in conjunction with 74283)
(For fecal instillation by oro-nasogastric tube or enema, use 44799)

Global Period: **XXX** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The IDSA, AGA and ASGE consulted with physicians who are familiar with the fecal microbiota transplant procedure to develop the practice expenses for the facility and nonfacility setting.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

While the practice expenses are somewhat different due to the nature of the service, our societies believe the best comparison was to code 99203; *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.*

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Staff conducts follow up phone call with donor regarding test results.

CPT Code:_44705__
Specialty Society(‘s)__IDSA, AGA, ASGE_

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Preparation of fecal microbiota for instillation, including assessment of donor specimen
(Do not report 44705 in conjunction with 74283)
(For fecal instillation by oro-nasogastric tube or enema, use 44799)

Global Period: **XXX** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The IDSA, AGA and ASGE consulted with physicians who are familiar with the fecal microbiota transplant procedure to develop the practice expenses for the facility and nonfacility setting.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

While the practice expenses are somewhat different due to the nature of the service, our societies believe the best comparison was to code 99203; *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.*

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Staff schedules the patient for the instillation. Staff assembles the necessary equipment used to produce the material for instillation. Staff receives the stool sample and confirms correct donor.

Service Clinical Labor Activities:

The donor stool is mixed with approximately 50 ml of preservative free normal saline in a blender to create a liquid slurry of fecal microbiota. The slurry is filtered twice to remove any and all particulate matter. The fecal microbiota sample is drawn into a syringe and labeled. The syringe of fecal microbiota is delivered to the procedure site and prepared for instillation into the recipient. Staff proceeds to clean the equipment utilized in the preparation of the fecal microbiota sample. Diagnostic forms and lab requisitions are completed.

Post-Service Clinical Labor Activities:

Staff conducts follow up phone call with donor regarding test results.

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2				99203		44705	
3	**Meeting Date: April 2012** **Tab: 18** **Specialty: IDSA, AGA, ASGE**	**CMS Code**	**Staff Type**	Office or other outpatient visit for the evaluation and management of a new patient, which requires		Preparation of fecal microbiota for instillation, including assessment of donor specimen	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**xxx**	**xxx**	**xxx**	**xxx**
6	**TOTAL CLINICAL LABOR TIME**			**51.0**	**0.0**	**65.0**	**3.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**2.0**	**0.0**	**2.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**43.0**	**0.0**	**60.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**6.0**	**0.0**	**3.0**	**3.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**	L037D	RN/LPN/MTA				
12	Assemble equipment	L037D	RN/LPN/MTA			**1**	
13	Receive and confirm sample	L037D	RN/LPN/MTA			**1**	
14	Other Clinical Activity - *specify: Review/read X-ray, lab, pathology reports*			**2**			
15	**End: When patient enters office/facility for surgery/procedure**						
16	**SERVICE PERIOD**						
17	**Start: When patient enters office/facility for surgery/procedure:**	L037D	RN/LPN/MTA				
18	Greet patient, provide gowning, ensure appropriate medical records are available			**3**			
19	Obtain vital signs			**5**			
20	Provide pre-service education/obtain consent			**9**			
21	Prepare room, equipment, supplies			**2**			
22	Setup scope (non facility setting only)						
23	Prepare and position patient/ monitor patient/ set up IV			**2**			
24	Sedate/apply anesthesia						
25	Other Clinical Activity - *specify: Coordinate home or outpatient care*			**2**			
26	Other Clinical Activity - *specify: Assist Physician during exam*			**5**			
27	**Intra-service**						
28	Measuring and blending sample	L037D	RN/LPN/MTA			**5**	
29	Filtering and manipulating sample x 2	L037D	RN/LPN/MTA			**45**	
30	Draw sample into syringe and label	L037D	RN/LPN/MTA			**3**	
31	**Post-Service**						
32	Deliver sample to procedure site	L037D	RN/LPN/MTA			**1**	
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
34	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			**3**	
35	Other Clinical Activity - *specify:*						
36	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	
37	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
38	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
39	Other Clinical Activity - *specify: Review history systems and medication*			**12**			
40	**End: Patient leaves office**						
41	**POST-SERVICE Period**						
42	**Start: Patient leaves office/facility**	L037D	RN/LPN/MTA				
43	conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**6**		**3**	**3**
52	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2				99203		44705	
3	**Meeting Date: April 2012** **Tab: 18** **Specialty: IDSA, AGA, ASGE**	**CMS Code**	**Staff Type**	Office or other outpatient visit for the evaluation and management of a new patient, which requires		Preparation of fecal microbiota for instillation, including assessment of donor specimen	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
53	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
54	beaker, 250 ml	SL018	item			**1**	
55	pyrex funnel						
56	syringe 50-60ml	SC056	item			**1**	
57	phosphate buffered saline solution	SL107	ml			**50**	
58	filter, nylon mesh (55mm)	SL066	item			**1**	
59	bleach	SL020	ml			**300**	
60	gown, staff, impervious	SB027	item			**1**	
61	eye shield, splash protection	SM016	item			**1**	
62	mask, surgical	SB033	item			**1**	
63	gloves, non-sterile	SB022	item			**1**	
64	toilet hat						
65	pack, EM visit	SA047	pack	**1**			
66	**EQUIPMENT**	**CODE**					
67	whip mixer	EP086				**5**	
68	hood, biohazard	EP016				**45**	
69	table, exam	EF023		**51**		**20**	
70	otoscope-ophthalmoscope (wall unit)	EQ189		**51**			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Bladder Chemodenervation

In February 2012, the CPT Panel created a new code, 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* to report physician work related to chemodenervation of the bladder. This procedure was previously reported using an unlisted code.

The RUC reviewed the survey results from 59 urologists and determined the survey respondents overestimated the physician work to perform this service. Additionally, there was consensus among the RUC that the survey median intra service time of 20 minutes was insufficient for a basic cystourethroscopy, which includes the work of CPT code 52000 (work RVU=2.23, intra service time=15 minutes) plus 30 injections. The RUC also agreed that this work was completely different than other chemodenervation treatments (e.g., migraine). The risks, including paralytic bladder, bleeding, perforation and urosepsis are significantly greater.

The RUC attempted to identify CPT codes with similar physician time and intensity. The RUC reviewed 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU=2.75) and 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and agreed that although theses procedures have the same intra-service time of 20 minutes, the intensity of 52287 is higher. The RUC reviewed 52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (work RVU=3.02) and determined that the physician work and intensity were similar. **The RUC recommends that 52287 be resurveyed in October 2012 to validate the intra service time. In the interim, the RUC recommends a work RVU of 3.02, a direct crosswalk to CPT code 52007, for CPT code 52287.**

Practice Expense:
The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
Surgery **Urinary System** **Bladder** **Transurethral Surgery**				
●52287	JJ1	Cystourethroscopy, with injection(s) for chemodenervation of the bladder (report supply separately) (The supply of the chemodenervation agent is reported separately)	000	3.02 (Interim) Re-survey for October 2012

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:52287 Tracking Number JJ1 Original Specialty Recommended RVU: **3.95**
Presented Recommended RVU: **3.74**
Global Period: 000 RUC Recommended RVU: **3.02**

CPT Descriptor: CYSTOURETHROSCOPY, WITH INJECTION(S) FOR CHEMODENERVATION OF THE BLADDER

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46 year old female presents with urinary incontinence due to neurogenic detrusor overactivity. The patient is experiencing urinary urgency, frequency and urgency incontinence several times daily. Prior evaluation has consisted of a negative urine culture and cytology, diagnostic cystoscopy that was consistent with evidence of detrusor hyperactivity, and urodynamics that demonstrated uninhibited detrusor contractions in the absence of anatomical obstruction. The patient has failed oral anticholinergic/antimuscarinic medications and is scheduled for treatment with chemodenervation of the bladder by intravesical injection of a neurotoxic agent.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 40%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 11%

Description of Pre-Service Work:

• Obtain and review records and previous history, laboratory studies and all imaging studies before the procedure;
•Surgical time-out is done identifying the patient, procedure to be done, and appropriate equipment and supplies are in the room
•Place patient on cystoscopy table in dorsal-lithotomy position
•Prep and drape the perineum
•Connect irrigation tubing and light source to flexible cystoscope
•Drain bladder using straight catheter
•Instill 50 ml of 2% Xylocaine into bladder
•Wait 10 minutes for Xylocaine to take effect and numb bladder
•Connect laser and insert through working channel of flexible cystoscope
•Attach camera and “white balance”; check video equipment
•Prepare drug - vacuum-dried, purified onabotulinumtoxinA (100 U per vial) is reconstituted in 10 mL of sterile 0.9% non-preserved saline solution and mixed gently to yield a 10unit/1cc saline dilution. The reconstituted drug is drawn into a sterile 10mL syringe onto the surgical field from the vial of reconstituted drug. This produces one 10 mL syringe of reconstituted onabotulinumtoxinA with a dilution of 10units/1cc saline. Up to 3 vials of

onabotulinumtoxinA may be used, requiring 3 vials be reconstituted and a total dose of 300U drug delivered.

Description of Intra-Service Work:

•Prior to injection, the syringe containing the reconstituted drug is attached to the cystoscopic injection needle which is then primed with approximately 1ml diluted drug to remove any air.

•On the sterile field, the cystoscopic injection needle is loaded into the working channel of the cystoscope.

•The cystoscope is inserted through the patient's urethra into the bladder under direct visualization.

•Document procedure with still photographs from video unit and transfer images to medical record

•The urinary bladder is distended to near capacity with approximately 300cc cystoscopic irrigant using sterile normal saline.

•Under direct vision, the surgeon places the cystoscopic needle at 2-4mm of depth into the bladder detrussor muscle assuring the needle depth has not perforated the bladder. The surgeon holds steady positioning of the needle in the bladder muscle. The surgeon directs the assistant to press 1/2 to 1 cc of drug from the syringe as the surgeon observes the injection bleb of drug delivered to the bladder muscle. (ie, this is a 4-handed maneuver requiring an assistant, the surgeon cannot watch the bladder and the syringe at the same time - thus requiring an assistant.) This injection maneuver is repeated 10-60 times, spacing injections 1cm apart and dispersing injections evenly throughout the bladder muscle taking care to avoid critical landmarks and vascular structures. For the final injection, approximately 1 mL of sterile saline is injected so the full dose is delivered.

•At the end of the injection procedure, the bladder is drained, and the cystoscope is reinserted to refill the bladder and observe for any bleeding and assure no perforations or injuries have occurred. The bladder is redrained at the end of the procedure.

Description of Post-Service Work:

•Remove drapes
•Bring patient's legs out of dorsal-lithotomy position
•Move patient off of table and take to recovery area
•Monitor vital signs as appropriate
•Discuss findings with patient and family as appropriate
•Give post operative instruction sheet
•Write prescriptions
•Schedule follow-up appointment
•Dictate operative report
•Contact referring physician or primary care physician as appropriate

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Thomas Cooper, MD; Christopher Gonzalez, MD; Thomas Turk, MD, Stephanie Klieb, MD;		
Specialty(s):	Urology		
CPT Code:	52287		
Sample Size:	129	**Resp N:** 59	**Response:** 45.7 %
Description of Sample:	The specialty society sent an email to a random 2,000 of 8,000 urologists to solicit interest in a survey. Of those 2,000 urologist, 129 expressed interest in participating with 59 responses.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**8.00**	12.00	50.00
Survey RVW:	2.60	3.95	**5.20**	6.25	12.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	20.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	52287	**Recommended Physician Work RVU: 3.02**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**0.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**0.00**	**10.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
51715	000	3.73	**RUC Time**

CPT Descriptor ENDOSCOPIC INJECTION OF IMPLANT MATERIAL INTO THE SUBMUCOSAL TISSUES OF THE URETHRA AND/OR BLADDER NECK

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
51102	000	2.70	**RUC Time**	13,936

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 37.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 52287**	**Key Reference CPT Code:** 51715	**Source of Time** **RUC Time**
Median Pre-Service Time	22.00	30.00	
Median Intra-Service Time	20.00	45.00	
Median Immediate Post-service Time	20.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**62.00**	**135.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.05	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	3.64
Urgency of medical decision making	2.82	2.59
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.55	3.59
Physical effort required	3.09	2.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.32	2.86
Outcome depends on the skill and judgment of physician	3.82	3.82
Estimated risk of malpractice suit with poor outcome	2.95	2.82

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.55	3.15
Intra-Service intensity/complexity	3.55	3.09
Post-Service intensity/complexity	2.86	2.86

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 53899

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 40000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The information is based on coverage data from the National Ambulatory Care and National Hospital Ambulatory Care payer surveys.

Specialty Urology Frequency 35000 Percentage 87.50 %

Specialty Urogynecology Frequency 5000 Percentage 12.50 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 16,800 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The information is based on coverage data from the National Ambulatory Care and National Hospital Ambulatory Care payer surveys.

Specialty Urology Frequency 11000 Percentage 65.47 %

Specialty Urogynecology Frequency 4800 Percentage 28.57 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 51715

SS Rec Summary

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
12	**ISSUE:**	**Bladder Chemodenervation**																		
13	**TAB:**	**19**																		
14						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
16	**REF**	**51715**	**Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck**		**0.0381**			**3.73**			**135**	**30**					**45**			**60**
17	**CURRENT**	**52287**	**Cystourethroscopy, with injection(s) for chemodenervation of the bladder**				**NEW CODE**													
18	**SVY**	**52287**	**Cystourethroscopy, with injection(s) for chemodenervation of the bladder**	**59**	**0.2035**	**2.60**	**3.95**	**5.20**	**6.25**	**12.00**	**80**	**15**	**10**	**15**	**15**	**20**	**20**	**30**	**60**	**20**
19	**REC**	**52287**	**Cystourethroscopy, with injection(s) for chemodenervation of the bladder**		**0.1111**			**3.02**			**62**	**7**	**5**	**10**			**20**			**20**
20																				
21																				
22																				
23																				
24																				
25																				

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: Cystourethroscopy, with injection(s) for chemodenervation of the bladder

Global Period: 000 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AUA expert panel consists of ten urologists who represent urological practices, both academic and private settings, from across the United States. They represent the states of Washington, Illinois, New York, Kentucky, Florida and Tennessee. The information was also reviewed by a member of the American Urogynecologic Society. The panel reviews current RUC practice expense information, requests input for supplies and equipment from several urology practices, reviews the information, makes recommendations and submits them to the AMA.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: We used the key reference code 51715 Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck as a comparison code for practice expense inputs.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Chart is reviewed by clinical staff to verify that correct procedure is ordered for the patient.
- Room is prepared and exam table is covered with paper.
- Patient is greeted and a gown is provided.
- Patient education and consent is obtained.
- Review with patient each step of the treatment and answer patient questions.
- Obtain vitals
- Set up the equipment (cystoscope, video, etc.) and sets up the supplies needed for the procedure.
- Assist the physician with positioning and padding of patient in the dorsal lithotomy position.
- Assist the physician with the preparation and draping of the patient.
- Assist the physician with the local anesthesia prior to the procedure.

Service Clinical Labor Activities:

- Performs a time-out with physician to make sure proper procedure and proper patient is being treated.

- Clinical staff person hands supplies and equipment to the physician during procedure.
- Assist the physician with removing padding and repositioning patient after procedure.

Post-Service Clinical Labor Activities:

- Clean the room and disinfect cystoscope in proper sterilizing equipment and according to sterilization protocols.
- Provide follow up information to patient.
- Discuss any adverse reaction at insertion site.
- Confers with the MD verbally for any last minute instructions for patient.
- Next appointment is set up for patient while checking out.

	A	B	C	D	E	F	G
1	REVISED 4/26/2012			REFERENCE CODE			
2				CPT Code # 51715		CPT Code # 52287	
3	**Meeting Date: April 2012** **Tab: 19** **Specialty: American Urological Association**	**CMS Code**	**Staff Type**	CPT CODE DESCRIPTOR: Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck		CPT CODE DESCRIPTOR: Cystourethroscopy with injection(s) for chemodenervation of the bladder	
4	**LOCATION**	**L037D**	**RN/LPN/MTA**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD: 000**	**L037D**	**RN/LPN/MTA**				
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**81.0**	**25.0**	**81.0**	**18.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**18.0**	**22.0**	**0.0**	**15.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**60.0**	**0.0**	**78.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**3.0**	**3.0**	**3.0**	**3.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	**RN/LPN/MTA**	**5**	**5**		**3**
13	Coordinate pre-surgery services	**L037D**	**RN/LPN/MTA**	**3**	**5**		**3**
14	Schedule space and equipment in facility	**L037D**	**RN/LPN/MTA**		**5**		**3**
15	Provide pre-service education/obtain consent	**L037D**	**RN/LPN/MTA**	**7**	**7**		**3**
16	Follow-up phone calls & prescriptions	**L037D**	**RN/LPN/MTA**	**3**			**3**
17	Other Clinical Activity - *specify:*						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available	**L037D**	**RN/LPN/MTA**	**3**		**3**	
22	Obtain vital signs	**L037D**	**RN/LPN/MTA**	**3**		**3**	
23	Provide pre-service education/obtain consent	**L037D**	**RN/LPN/MTA**			**3**	
24	Prepare room, equipment, supplies	**L037D**	**RN/LPN/MTA**	**2**		**2**	
25	Setup scope (non facility setting only)	**L037D**	**RN/LPN/MTA**	**5**		**5**	
26	Prepare and position patient/ monitor patient	**L037D**	**RN/LPN/MTA**	**2**		**2**	
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	**L037D**	**RN/LPN/MTA**	**30**		**20**	
30	**Post-Service**						
31	Monitor pt. following service/recheck vitals	**L037D**	**RN/LPN/MTA**	**2**		**2**	
32	Clean room/equipment by physician staff	**L037D**	**RN/LPN/MTA**	**3**		**3**	
33	Clean Scope	**L037D**	**RN/LPN/MTA**	**10**		**30**	
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Home care instructions /coordinate office visits /prescriptions	**L037D**	**RN/LPN/MTA**			**5**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	**L037D**	**RN/LPN/MTA**	**3**	**3**	**3**	**3**
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*						
54	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	REVISED 4/26/2012			REFERENCE CODE			
2				CPT Code # 51715		CPT Code # 52287	
3	**Meeting Date: April 2012** **Tab: 19** **Specialty: American Urological Association**	CMS Code	Staff Type	CPT CODE DESCRIPTOR: Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck		CPT CODE DESCRIPTOR: Cystourethroscopy with injection(s) for chemodenervation of the bladder	
4	**LOCATION**	**L037D**	**RN/LPN/MTA**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD: 000**	**L037D**	**RN/LPN/MTA**				
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	water, sterile for irrigation (250-1000ml uou)	SH074	item	1		**1**	
57	pack, cleaning and disinfecting, endoscope	SA042	pack	1		**1**	
58	pack, urology cystoscopy visit	SA058	pack	1		**1**	
59	pack, minimum multi-specialty visit	SA048	pack	1		**1**	
60	catheter, Foley	SD024	item	1			
61	needle, 18-26g 1.5-3.5in, spinal	SC028	item	1			
62	catheter, straight	SD030	item			**1**	
63	lidocaine, 2% jelly topical (Xylocaine)	SH048	ml			**10**	
64	gloves, sterile	SB024	pair			**4**	
65	syringe, Toomey	SC062	item			**1**	
66	injection needle for cystoscope (see invoice)	New	item			**1**	
67	drape, sterile, for Mayo stand	SB012	item			**1**	
68	lubricating jelly (K-Y)(5 gm uou)	SJ032	item			**1**	
69	scissors	SA027	item			**1**	
70	syringe, 50-60 ml	SC056	item			**1**	
71	needle, 30 g	SC031	item			**2**	
72	Sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			**4**	
73	10 cc syringe	SC051	item			**4**	
74	lidocaine 1%-2% inj (Xylocaine)	SH047	ml			**50**	
75	sodium chloride, 0.9% inj (10 ml uou)	SH066	ml			**3**	
76	**EQUIPMENT**	**CODE**					
77	endoscope, rigid, cystoscopy	ES008		1			
78	light, fiberoptic headlight w-source	EQ170		1			
79	table, power	EF031		1			
80							
81	cystoscope, flexible, Fiberscope	ES018				**78**	
82	Video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				**78**	
83	light, fiberoptic headlight w source	EQ170				**78**	
84	table, power	EF031				**78**	
85	mobile back table with wheels	EF027				**78**	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Chemodenervation for Chronic Migraine and Related Family

In February 2012, the CPT Editorial Panel created one new code to describe a new injection paradigm for treatment of chronic migraine as current codes do not describe the totality of the work performed. The Panel also revised 64612 to indicate that this service is unilateral as well as clarify the parenthetical following 64614. The entire family was to be surveyed to avoid any rank order anomalies.

64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
The RUC reviewed the survey results from 50 ophthalmologists, neurologists, physical and rehabilitation physicians and interventional pain physicians and determined that the survey median work RVU of 1.41, a decrease from the current value, appropriately accounts for the work required to perform this service. The RUC agreed with the survey respondents that 10 minutes pre-time, 10 minutes intra-service time and 5 minutes post-time are required to perform this service. Although the survey respondents indicated that one 99213 office visit is typically performed in the global period for this service, the RUC agreed with the specialties that one 99212 office visit is more appropriate.

The RUC compared 64612 to key reference service 64611 *Chemodenervation of parotid and submandibular salivary glands, bilateral* (work RVU = 1.03 and 5 minutes intra-service time) and determined that 64612 requires twice as much intra-service time, more physician work and is more intense and complex. The RUC also compared 64612 to MPC code 41100 *Biopsy of tongue; anterior two-thirds* (work RVU = 1.42 and 15 minutes intra-service time) and 68840 *Probing of lacrimal canaliculi, with or without irrigation* (work RVU = 1.30 and 10 minutes intra-service time) and determined that a work RVU of 1.41 places this service in the proper rank order among similar services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 1.41 for CPT code 64612.**

64613 Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)
The American Academy of Neurology (AAN), the American Society of Interventional Pain Physicians (ASIPP), the American Academy of Physical Medicine and Rehabilitation (AAPM&R) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) surveyed 64613 and indicated that the current parenthetical has a multi-purpose use for spasmodic torticollis and spasmodic dysphonia. The specialties believe that the varied data is due to the different uses of this procedures when performed by an otolaryngologist who is injecting the larynx versus the other three specialties who are injecting into a neck muscle. All specialties agree that injecting into the larynx is substantially different work than injecting the neck muscle. The specialty societies requested and the RUC agreed that code 64613 be referred to the CPT Editorial Panel to create two codes to describe two separate and distinct services. **The RUC recommends that 64613 be referred to the CPT Editorial panel to create two codes, one to describe chemodenervation for spasmodic torticollis and another to describe chemodenervation for spasmodic dysphonia.**

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64614 Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)
The specialty societies indicated that CPT code 64614 was included to be surveyed as part of this family of services. However, AAN and AAPM&R recently submitted a code change proposal to split 64614 into two new codes. **The specialties requested and the RUC agreed to postpone review of this service until the October 2012 RUC meeting.**

64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
The RUC reviewed the survey results from 41 ophthalmologists, neurologists, physical and rehabilitation physicians and interventional pain physicians and determined that the survey median work RVU of 1.85 appropriately accounts for the work required to perform this service. The RUC determined that 15 minutes pre-time, 15 minutes intra-service time and 5 minutes post-time are required to perform this service. The survey respondents did not indicate that a post-operative office visit is typical, the specialty societies agreed and requests that CMS change this service to a 000-day global period.

The RUC compared 64615 to 70546 *Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 1.80 and 15 minutes intra-service time) and determined that these services require similar physician work, intensity, complexity and intra-service time to perform. The RUC also compared 64615 to MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.22 and 25 minutes intra-service time) and determined that a work RVU of 1.85 places this service in the proper rank order among similar services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 1.85 and requests a 000-global period for CPT code 64615.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Surgery** **Nervous System** **Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency, Chemodenervation)**				
Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids). Do not report diagnostic/therapeutic injections separately. ~~(For~~ Do not report a code labeled as destruction when using therapies that are not destructive of the target nerve [eg, pulsed radiofrequency], use 64999~~)~~. For codes labeled as chemodenervation, the supply of the chemodenervation agent is reported separately. (For chemodenervation of internal anal sphincter, use 46505) (For chemodenervation of the bladder, use 528XX) (For chemodenervation for strabismus involving the extraocular muscles, use 67345) (For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)				
Somatic Nerves				
▲64612	DD1	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm) (To report a bilateral procedure, use modifier 50)	010	1.41
64613	DD2	neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia) (Report 64613 only once per session) Do not report 64613 with modifier 50)	010	Specialties Request Referral to CPT Editorial Panel

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▲64614	DD3	extremity~~(s)~~ and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis) ~~(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)~~ ~~(For chemodenervation for strabismus involving the extraocular muscles, use 67345)~~ ~~For chemodenervation of internal anal sphincter, use 46505)~~ (Report 64614 only once per session)	010	Specialties Request Postponement to October 2012
●64615	DD4	muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine) (Report 64615 only once per session) (Do not report 64615 in conjunction with 64612, 64613, 64614)	~~010~~ 000	1.85

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April 2, 2012

Barbara Levy, M.D.
Chair, Relative Value Scale Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

RE: Tab 20: Chemodenervation for Chronic Migraine, CPT 64613 and 64614

Dear Dr. Levy:

Please accept this letter on behalf of the American Academy of Neurology (AAN), the American Society of Interventional Pain Physicians (ASIPP), the American Academy of Physical Medicine & Rehabilitation (AAMPR), and the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS). Together, our societies surveyed a family of three CPT codes; 64612, 64613, and 641X1, representing Tab 20 for the upcoming April Relative Update Committee (RUC) meeting.

We are writing to express our concerns with the survey responses received for CPT 64613 *Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia).* Specifically, upon review of the survey responses, it became evident that the responses from AAO-HNS members were markedly different, in work and intensity, than those received from AAN, ASIPP, and AAMPR. As you can see from the descriptor above, CPT 64613 includes a parenthetical which notes it has a multi-purpose use, for torticollis or dysphonia. We believe the varied data from our survey is due to the different uses of this procedure when performed by an Otolaryngologist who is injecting the larynx versus the other three specialties who are injecting a muscle in the neck. As a group, we agree that injecting the larynx is substantially different work than injecting the neck muscle; and therefore we believe new CPT codes for these separate and distinct purposes, spasmodic torticollis and spasmodic dysphonia, is appropriate.

After speaking with AMA staff assigned to this tab, we uniformly agree and respectfully request, that the RUC permit our specialties to table the valuation of CPT 64613 for the April RUC meeting and instead, proceed with code change applications for the October 2012 CPT Editorial panel meeting to request the development of two new CPT codes for Chemodenervation of muscle(s); for spasmodic dysphonia and Chemodenervation of muscle(s); for spasmodic torticollis. The estimated timeline, should the RUC approve this, would be for the respective societies to submit code change proposals (CCP) by the July 13, 2012 deadline for consideration at the October 2012 CPT Editorial Panel meeting. The new codes would then be valued by the RUC at the January 2013 RUC meeting.

While 64614 was also included on the level of interest form, AAN and AAPMR submitted a code change proposal in February to split 64614 into two new codes. For that reason, the societies will not survey that service until after CPT reviews it at the May 2012 meeting. The RUC may prefer that the new codes for existing services in 64613 and 64614 are brought to the same meeting in January 2013.

Thank you in advance for your consideration of this request and urge you to contact us with any questions or concerns regarding this proposal. You may reach the relevant Society staff at: Amanda Becker, AAN, at Abecker@aan.com or 651.695.2718; Melinda Martin, ASIPP, at mmartin@asipp.org or 270-554-9412;

Ana Maria Bustos, AAPMR, at abustos@aapmr.org or 847-737-6000; or Jenna Minton, AAO-HNS, at jminton@entnet.org or 703.535.3725.

Sincerely,

Kevin Kerber, MD
AAN RUC Advisor Alternate

David Caraway, MD, PhD
ASIPP RUC Advisor

Joseph Zuhosky, MD
AAPMR RUC Advisor

Wayne Koch, MD
AAO-HNS RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64612 Tracking Number DD1 Original Specialty Recommended RVU: **1.41**
Presented Recommended RVU: **1.41**
Global Period: 010 RUC Recommended RVU: **1.41**

CPT Descriptor: Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 year old man presents with nearly constant spasms of the left side of his face including the orbicularis oculi. Chemodenervation is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 2% , In the ASC 6%, In the office 92%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Description of Pre-Service Work: The physician reviews the patient history and confirms the eye for treatment. Effect of prior treatment is reviewed. Consent is obtained. Additional counseling of the patient and any accompanying family about the treatment planned is performed. The duration of expected treatment effect is discussed. The side to be treated is marked and time out taken. The medication is reconstituted with sterile saline by slowly injecting the diluent into the vial.The physician then gently mixes the toxin by rotating the vial. The drug is drawn into the syringe.

Description of Intra-Service Work: The facial muscles are injected in 6 to 8 locations: three in the brow, one in the lateral canthus, one or two in the lower lid, and one in the lateral aspect of the upper lid and when needed one in the nasal aspect of the upper lid. More muscles may be injected such as platysma and zygomaticus.

Description of Post-Service Work: The physician confirms the treatment and discusses necessary follow up. The service is documented in the medical record. Drug accounting is completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Stephen Kamenetzky, M.D. (AAO), Robert Weiss, M.D. (AAO), Kevin Kerber, M.D. (AAN), Joe Zuhosky, M.D.,					
Specialty(s):	American Academy of Ophthalmology, American Academy of Neurology, American Academy of Physical and Rehabilitation Medicine and American society of Interventional Pain Physicians					
CPT Code:	64612					
Sample Size:	900	**Resp N:**	50	**Response:** 5.5 %		
Description of Sample:	The groups involved used a mixture of a random sample of members and physicians who indicated they perform the service.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.25	**12.00**	50.00	150.00
Survey RVW:	0.80	1.03	**1.41**	1.94	3.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	2.00	5.00	**10.00**	15.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64612	**Recommended Physician Work RVU: 1.41**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**7.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64611	010	1.03	**RUC Time**

CPT Descriptor Chemodenervation of parotid and submandibular salivary glands, bilateral

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11440	010	1.05	**RUC Time**	49,000

CPT Descriptor 1 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
41100	010	1.42	**RUC Time**	7,400

CPT Descriptor 2 Biopsy of tongue; anterior two-thirds

Other Reference CPT Code	Global	Work RVU	Time Source
;64632	000	1.40	**RUC Time**

CPT Descriptor Destruction by neurolytic agent; plantar common digital nerve,

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 64612**	**Key Reference CPT Code:** 64611	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	10.00	5.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**41.00**	**36.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	2.93
Urgency of medical decision making	2.67	2.47
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.73
Physical effort required	2.60	2.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	3.00
Outcome depends on the skill and judgment of physician	4.20	3.87
Estimated risk of malpractice suit with poor outcome	2.53	2.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.27	3.20
Intra-Service intensity/complexity	3.33	3.20
Post-Service intensity/complexity	2.13	2.13

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code CPT 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)* is being presented as part of a family of codes dealing with chemodenervation of the muscles in the head and neck area. This code deals with treatment of spasms

of muscles of the face innervated by the facial nerve. Injection of the botulinum toxin causes paresis of the muscles and reduces the spasms. These facial injections of multiple muscles include the orbicularis oculi responsible for lid closure. There is significant skill and judgment required to determine both the precise locations for injection needed for each patient and the dose required to treat the disease without causing iatrogenic seventh nerve palsy with resulting exposure keratitis in the eye. The American Academy of Ophthalmology, American Academy of Neurology, American Academy of Physical and Rehabilitation Medicine and American society of Interventional Pain Physicians participated in the survey. The dominant specialty for the use of this office-based code is Ophthalmology. There were 50 respondents, 82% of whom felt the rationale accurately represented the typical patient. The code has a 10 day global period and is not typically performed with an EM service.

The current value of the code is 2.01 with times **of 10/20/6** minutes and **one level 99212** in the global period. It has an **IWPUT of .058**. The **median WRVU** from the survey was **1.41** with the **25th percentile 1.03**. Median IST was **10 minutes**. Total **pre-service time** from the survey was **20 minutes** with **5 minutes** of **post-service time**. The survey showed that a post-operative visit within the global period was typical and the expert panel agreed that the current 99212 should remain.

The key reference service was 64611, *Chemodenervation of parotid and submandibular salivary glands, bilateral,* which was reviewed by the RUC in June 2009. It has a 10-day global with one 99212 visit and **work RVU of 1.03**. The times for this code are 10/5/5 minutes. For 9 of 11 intensity measurements, the survey respondents felt that the surveyed code was more complex and intense than the reference code. An expert consensus panel composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey. It discussed the fact that the nature of the procedure has not changed significantly. The consensus group recommended the **pre-service package 5 with three additional minutes** added prepare the toxin. This is identical to both the package chosen and the RUC-reviewed time allowed for the reference code (10 minutes). The panel also noted that the surveyed code had an IST that was twice as long as the reference code and also higher intensity-complexity metrics. The panel therefore recommended that the **survey median 1.41 RVU** as accurately reflecting the WRVU for the surveyed service**. This is 0.6 RVU lower than the current value**.

The panel used several methods of verifying the recommended value. It first considered the comparison with the reference code 64611. The surveyed code has a longer IST (10 vs 5 min) and involves on average 6 separate injections in six distinct sites around an eye which must be carefully identified. Those surveyed felt that the current code was more complex and intense in 9 of 11 metrics. The iatrogenic risks are higher for facial injections in general and periocular injections in particular. Taking all of these issues into account, the panel felt that the recommended work value of 1.41 represented the proper incremental work increase for the surveyed code when compared with the reference code.

The panel also considered another 10-day global injection code, CPT 64632 *Destruction by neurolytic agent; plantar common digital nerve,* which was reviewed by the RUC in April 2008. This is a single needle placement in the foot with several redirections to spread the medication. It has a 10-day global with one 99212 visit, WRVU of 1.23 with the same pre and post times but only half the IST of the surveyed code. The panel felt that the longer IST, the work involved to identify multiple injection sites and the location of the injections around the eye justified a higher WRVU. CPT 68840 *Probing of lacrimal canaliculi, with or without irrigation* was reviewed by the RUC in 2005. It has virtually identical times and a WRVU of 1.30. The panel felt that this code was less intense and complex than the surveyed code and had a lower chance of developing a serious complication.

Because there are few injection codes with 10-day global periods, the panel also reviewed other injection codes with similar pre and post times but XXX AND 000 global periods. Removing one 99212 visit from our recommended value would give a **WRVU of 0.93** (=1.41-.48). CPT 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (RUC reviewed 2002, 000 global, 6/5/5

min) has **a WRVU of 0.94**. The panel felt that the work of the surveyed code was comparable to the work of this code which not only takes less time but involves a single injection of lower risk therapeutic agents (steroid/local anesthetic) in an area other than the face and eye.

We also considered that the current code has an IST of 20 minutes. The current survey showed 10 minutes of IST. The pre and post times are identical and the number and level of post-operative visits is the same. Using the current IWPUT of the code (0.058), removing 10 minutes of time would result in removing 0.58 WRVU. Subtracting this from the current value of the code (2.01) gives a value of 1.43 WRVU which is virtually identical to the recommended survey median (1.41 WRVU). The RUC has accepted this method of confirming the value of a code for which intensity and complexity have not changed, but time has decreased (most recently CPT 66984 in January 2012).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64612

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty Neurology How often? Sometimes

Specialty Physical/Rehab How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Unknown
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 86,957 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Reduction due to utilization shift to new migraine injection code

Specialty Ophthalmology Frequency 60870 Percentage 70.00 %

Specialty Neurology Frequency 24845 Percentage 28.57 %

Specialty Physical/Rehab Frequency 1500 Percentage 1.76 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64612

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64615 Tracking Number DD4 Original Specialty Recommended RVU: **1.85**
Presented Recommended RVU: **1.85**
Global Period: 000 RUC Recommended RVU: **1.85**

CPT Descriptor: Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46 year old woman presents with 19 headache days per month of which 15 or more meet the criteria for migraine (headache lasting 4 hours per day or longer). The decision is made to chemodenervate muscles innervated by the facial, trigeminal, cervical spinal and accessory nerves.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 2% , In the ASC 7%, In the office 90%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

Description of Pre-Service Work: The physician reviews the patient history and consents the patient. Effect of prior treatment is reviewed. Additional counseling of the patient and any accompanying family about the treatment planned is performed. The duration of expected treatment effect is discussed.The medication is reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The physician records the date and time of reconstitution. The drug is drawn into the syringe.

Description of Intra-Service Work: The physician identifies 31 injection sites over 7 muscle groups on each side of the face, head, neck and upper back (the frontalis, corrugator, procerus, occipitalis, temporalis, trapezius, and cervical paraspinal muscle groups). The physician prepares each of the injection sites by cleaning with alcohol. The physician injects, controls bleeding, and ensures patient is stable.

Description of Post-Service Work: Post-injection instructions are provided including expected side effects including pain or weakness in injected areas, The patient is advised to report promptly any shortness of breath, generalized weakness, or weakness outside of the injected regions. The service is documented in the medical record. Drug accounting is completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Kevin Kerber, MD (AAN); Joe Zuhosky, MD (AAPMR);Stephen Kamenetzky,MD (AAO)					
Specialty(s):	AAN, AANEM, AAO, ASIPP					
CPT Code:	64615					
Sample Size:	908	**Resp N:**	41	**Response:** 4.5 %		
Description of Sample:	Random - a mixture of a random list of members and physicians who indicated they perform the service					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**20.00**	50.00	100.00	
Survey RVW:	0.85	1.20	**1.85**	2.10	4.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	4.00	10.00	**15.00**	20.00	30.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64615	**Recommended Physician Work RVU: 1.85**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**7.00**	**8.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64653	000	0.88	**RUC Time**

CPT Descriptor CHEMODENERVATION OF ECCRINE GLANDS; OTHER AREA(S) (EG, SCALP, FACE, NECK), PER DAY

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92004	XXX	1.82	**RUC Time**	2,123,579

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99385	XXX	1.92	**RUC Time**	

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 24.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 64615**	**Key Reference CPT Code:** 64653	**Source of Time** **RUC Time**
Median Pre-Service Time	15.00	7.00	
Median Intra-Service Time	15.00	23.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**35.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.30	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.00
Urgency of medical decision making	2.20	2.30
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.40	3.40
Physical effort required	2.80	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	2.90
Outcome depends on the skill and judgment of physician	3.40	3.40
Estimated risk of malpractice suit with poor outcome	2.90	2.90

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	3.00
Intra-Service intensity/complexity	3.30	3.10
Post-Service intensity/complexity	2.50	2.60

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Chemodenervation treatment for migraine requires a minimum of 31 injections, and potentially up to 39 injections, in head and neck muscles. The physician must map out specific locations for the 31 sites. Potential side effects include neck

pain/weakness, headache, and migraine. There is significant skill and judgment required to determine both the precise locations for injection needed for each patient and the dose required.

An expert consensus panel composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey. The group recommended the pre-service package 5 with three additional minutes added to prepare the toxin. This is identical to the pre-service time for code 64612.

When examining the survey times broken out by specialty, the neurology respondents gave a median intra-service time of 20 minutes. Neurology is the dominant provider and this fits with the time our experts state as realistic. The panel recommends an intra-time of 20 minutes.

Since the survey results did not show a follow-up visit was typical within 10 days, the societies recommend the global period change to 000.

The panel recommends the median RVU of 1.85 and times of 10/20/5 minutes.

This service requires more injections, more effort, and more intensity than 64612.

The panel considered code 70546, *Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences*, as a crosswalk. This service was reviewed by the RUC in April 2000. It has an XXX global with times of 6/15/10 and an RVU of 1.80.

The panels reviewed the times and values for other injection codes, as shown in this table. The high IWPUT support the value of 64615. The value for providing codes 20553, 20550, and 64455 would be 2.25 RVUs, and which comes in higher than 64615.

Code	Short Desc	RVW	Pre	Intra	Post	IWPUT
20552	Inj trigger point 1-2 muscl	0.66	5	5	3.5	0.0939
20553	Inject trigger pints =/>3	0.75	7	10	5	0.0481
20550	Inj tendon sheath/ligament	0.75	10	5	5	0.0828
64455	N block inj plantar digit	0.75	10	5	5	0.0828
20551	Inj tendon origin/insertion	0.75	10	5	5	0.0828
20526	Ther injection carp tunnel	0.94	6	5	5	0.1387

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Combination of previously existing codes 64612 and 64613, as well as the unlisted procedure code 64999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty Ophthalmology How often? Commonly

Specialty PM&R How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
12,358 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate 12% of 64612 was for migraine and 6% of 64999

Specialty Neurology Frequency 7661 Percentage 61.99 %

Specialty Ophthalmology Frequency 3378 Percentage 27.33 %

Specialty PM&R Frequency 1000 Percentage 8.09 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64612

SS Rec Summary

ISSUE: Chemodenervation for Chronic Migraine and Related Family

TAB: 20

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	Office 15	Office 14	Office 13	Office 12	Office 11
REF	64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	15	0.043			1.03			36	10					5			5				1	
CMS / Other	64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)		0.059			2.01			52	10					20			6				1	
SVY	64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)	50	-0.005	8.00	1.03	1.41	1.94	3.00	58	10	5	5	2	5	10	15	30	5			1		
REC	64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)		0.059			1.41			41	10					10			5				1	
MPC	11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less		0.035			1.05			36	5					10			5				1	
MPC	41100	Biopsy of tongue; anterior two-thirds		0.010			1.42			66	25					15			10				1	
comparison	64632	Destruction by neurolytic agent; plantar common digital nerve		0.083			1.23			36	10					5			5				1	
comparison	68840	Probing of lacrimal canaliculi, with or without irrigation		0.053			1.30			39	8					10			5				1	

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	Office 15	Office 14	Office 13	Office 12	Office 11
REF	64653	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	10	0.027			0.88			35	5	2				23			5					
SVY	64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	41	0.091	0.85	1.20	1.85	2.10	4.00	40	10	5	5	4	10	15	20	30	5					
REC	64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)		0.093			1.85			35	15					15			5					
comparison	70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences		0.096			1.80			31	6					15			10					
MPC	92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits		0.059			1.82			40	5					25			10					
MPC	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years		0.053			1.92			45	5					30			10					

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)

Global Period: **010** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The societies convened a panel of experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **This is an existing code and so the current inputs of 64612 should be compared.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The RN or tech completes the necessary referral forms from the facility where the procedure is to be performed. They then phone the facility to schedule the time that the patient would be seen for the injections. The informed consent provided by the physician is reiterated by the tech or RN who then assures that the appropriate forms are also signed by the patient.

Service Clinical Labor Activities:

Not applicable

Post-Service Clinical Labor Activities:

The RN or tech phones the patient to go over post-operative instructions regarding the injection sites as well as to reiterate emergent post-operative complications such as nerve palsy or infection the patient should be aware of and reported to the office. Taking care of non-emergent side effects such as dry eye are also discussed. Arrangements for a post-operative visit in order to access the treatment adequacy and ensure no post-operative impact on the eye are also made by the RN or tech.

CPT Code: 64615
Specialty Society('s) AAN, AAO, AAPMR, ASIPP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

Global Period: **010** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The societies convened a panel experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **The comparison code is 64612, which is a similar code within the family.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The RN or tech completes the necessary referral forms from the facility where the procedure is to be performed. They then phone the facility to schedule the time that the patient would be seen for the injections. The informed consent provided by the physician is reiterated by the tech or RN who then assures that the appropriate forms are also signed by the patient.

Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

Staff handles any follow-up phone calls from the patient.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

Global Period: **010** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The societies convened a panel experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **The comparison code is 64612, which is a similar code within the family.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient's appointment is made/confirmed and pre-procedure instructions are conveyed.

Service Clinical Labor Activities:

Verification of appropriate supplies to administer the toxin are made on an ongoing basis. Toxin is ordered from the pharmacy as needed and stored as appropriate for each brand drug. Appropriate storage of the toxin needs to be maintained, including daily monitoring of the refrigerator temperature and log of the drug stored. The drug is stored locked due to its high cost. On the day of the procedure, patient has vital signs done and the patient is put into a room. Medications are reviewed for contraindications to botulinum toxin. Informational material about the toxin is provided to the patient to review. Consent form is provided to the patients and signed. Patient is instructed to change into gown. Botulinum toxin is then reconstituted, and drawn into syringes. Syringes, needles, alcohol swab are then brought to the procedure room for administration.

Pressure apply to ensure bleeding has stopped, if needed. Patient dresses. Room is cleaned.

Post-Service Clinical Labor Activities:

Staff handles any follow-up phone calls from the patient.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)

Global Period: **010** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The societies convened a panel of experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **This is an existing code so the current inputs for 64612 should be compared.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The RN or ophthalmic tech reiterates the informed consent provided by the physician and assures that the appropriate forms are signed by the patient.

Service Clinical Labor Activities:

The clinical staff confirms that all the medical records are available. The RN or ophthalmic tech then prepares the screening lane or room to ensure that all supplies and equipment are available. The RN or tech greet the patient, confirm the treatment and correct side for treatment, provide appropriate gowning and obtain the necessary vital signs. The clinical staff will review the injections site and go over post-operative instructions. Following the drug accounting by the physician, the staff then provides appropriate information for the botox drug log. Once the procedure is completed and the patient has been escorted to the administrative area, the clinical staff clean the lane or room.

Post-Service Clinical Labor Activities:

The RN or tech phones the patient to go over post-operative instructions regarding the injection sites as well as to reiterate emergent post-operative complications such as nerve palsy or infection the patient should be aware of and reported to the office. Taking care of non-emergent side effects such as dry eye are also discussed. Arrangements for a post-operative visit in order to access the treatment adequacy and ensure no post-operative impact on the eye are also made by the RN or tech.

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2				64612		64612		64615	
3	**Meeting Date: April 2012** **Tab: 20** **Specialty: AAN, AAO, AAPMR, ASIPP**	**CMS Code**	**Staff Type**	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm,		Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm,		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**010**	**010**	**010**	**010**	**010**	**010**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**50.0**	**43.0**	**51.0**	**39.0**	**24.0**	**12.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**5.0**	**10.0**	**3.0**	**9.0**	**3.0**	**9.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**18.0**	**6.0**	**18.0**	**0.0**	**18.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**27.0**	**27.0**	**30.0**	**30.0**	**3.0**	**3.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms						**3**		**3**
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility						**3**		**3**
15	Provide pre-service education/obtain consent					**3**	**3**	**3**	**3**
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - *specify:*								
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available					**2**		**2**	
22	Obtain vital signs					**3**		**3**	
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies					**2**		**2**	
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure					**0**			
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff					**3**		**3**	
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					**5**		**5**	
38	Other Clinical Activity - *specify:complete Botox log*					**3**		**3**	
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions					**3**	**3**	**3**	**3**
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27			**1**	**1**		
49	99213 36 minutes		36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**0.0**	**0.0**	**27.0**	**27.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2				64612		64612		64615	
3	**Meeting Date: April 2012** **Tab: 20** **Specialty: AAN, AAO, AAPMR, ASIPP**	**CMS Code**	**Staff Type**	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm,		Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm,		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**010**	**010**	**010**	**010**	**010**	**010**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	pack, minimum multi-specialty visit	SA048	pack	**1**	**1**			**1**	**1**
57	pack, ophthalmology visit (non-dilation)	SA050	pack	**2**	**1**	**2**	**1**		
58	needle, 30g	SC031	item	**2**		**2**		**6**	
59	phosphate buffered saline solution	SL107	ml	**4**		**3**		**3**	
60	syringe 1ml	SC052	item	**1**		**1**		**6**	
61	syringe 3ml	SC055	item	**1**				**2**	
62	gauze, non-sterile 4in x 4in	SG051	item	**1**				**1**	
63	swab-pad, alcohol	SJ053	item	**1**		**3**		**3**	
64	syringe 5-6ml	SC057	item			**1**			
65	needle, 18-27g	SC029	item			**1**		**2**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item					**1**	
67									
68	**EQUIPMENT**	**CODE**							
69	lane, screening (oph)	EL006		**45**	**27**	**48**	**39**		
70	table, exam	EF023		**85**	**0**			**24**	
71									
72									
73									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued - Utilization over 30,000 screen

April 2012

Paracentesis of the Eye

In April 2011 the RUC identified CPT code 65805 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* through the Harvard-Valued Utilization over 30,000 screen and in September 2011 added 65800 to review as part of this family of services. In February 2012, specialty society brought forth a coding proposal to the CPT Editorial Panel to delete 65805 and revise 65800 as these services describe essentially the same procedure and are currently valued the same.

The RUC reviewed the survey results from 34 ophthalmologists and determined that the survey median work RVU of 1.53, lower than the current value, appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 12 minutes pre-evaluation, 1 minute pre-positioning and 5 minutes scrub, dress, wait time to administer topical anesthesia, insert lead, apply betadine and finally apply the gelatinous anesthetic; 5 minutes intra-service time and 5 minutes immediate post-service time. There are several codes that are similar in work and intensity to 65800. CPT *67028 Intravitreal injection of a pharmacologic agent (separate procedure)* reviewed in 2009 has a WRVU of 1.44 with times of 12/5/5. Both involve penetration of the eye with a needle and the risk of damage to internal structures. The RUC felt that the work of 67028 was similar to that of CPT 67515 *Injection of medication or other substance into Tenon's capsule* (RUC 2005, 000, 11/5/5) which has a WRVU of 1.40. CPT *67500 Retrobulbar injection; medication (separate procedure, does not include supply of medication)* (RUC 2005, 000, 15/5/5) has similar times and intensities with a WRVU of 1.44. Both of these procedures involve extraocular injections. Because the risk of serious damage from an intraocular injection is greater than an extraocular injection, the panel felt that the value of 65800 should be slightly higher. **The RUC recommends the median of the survey WRVU 1.53 as the proper value for the procedure.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲65800	K1	Paracentesis of anterior chamber of eye (separate procedure); with ~~diagnostic aspiration~~ removal of aqueous	000	1.53
D 65805		~~with therapeutic release of aqueous~~ (65805 has been deleted. To report, use 65800)	000	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:65800 Tracking Number K1 Original Specialty Recommended RVU: **1.53**
Presented Recommended RVU: **1.53**
Global Period: 000 RUC Recommended RVU: **1.53**

CPT Descriptor: Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year old patient presents six months after trabeculectomy with a hypopyon

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 9%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work: Review patient record. Obtain consent. Write preoperative orders for medications, pupillary dilation, and antibiotic prophylaxis. Select appropriate anesthesia. Discuss surgery with patient and family. Verify operative eye and mark. The patient is positioned in the operative chair in the screening lane. Perform surgical 'time out' with the operative team. After appropriate anesthesia is administered, the eye is prepped and draped

Description of Intra-Service Work: The slit lamp is positioned to identify the operative field. The globe is grasped with micro-forceps and a 25 gauge needle on a syringe is positioned at the limbus, parallel to the iris plane. The needle is advanced through the cornea with the bevel oriented up, entering the anterior chamber, while remaining above the iris. A sample of aqueous is aspirated from the eye. The needle is removed. The physician plates samples onto 3-4 prepared culture media and a glass microscope slide.

Description of Post-Service Work: An operative report is prepared. The sample is sent to microbiology for gram stain and culture. Results are relayed to patient and treatment plan is determined.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Stephen A.. Kamenetzky, M.D. and David Glasser, M.D.		
Specialty(s):	American Academy of Ophthalmology		
CPT Code:	65800		
Sample Size:	500	**Resp N:** 34	**Response:** 6.8 %
Description of Sample:	A random sample was selected from members who indciated an interest in cornea and retina as well as comprehensive ophthalmologists		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.25	**3.50**	10.00	100.00
Survey RVW:	1.40	1.48	**1.53**	2.00	4.00
Pre-Service Evaluation Time:			**12.50**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	5.00	**5.00**	10.00	20.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	65800	**Recommended Physician Work RVU: 1.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**12.00**	**17.00**	**-5.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65430	000	1.47	**RUC Time**

CPT Descriptor Scraping of cornea, diagnostic, for smear and/or culture

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
56605	000	1.10	**RUC Time**	27,176

CPT Descriptor 1 Biopsy of vulva or perineum (separate procedure); 1 lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29445	000	1.78	**RUC Time**	16,943

CPT Descriptor 2 Application of rigid total contact leg cast

Other Reference CPT Code	Global	Work RVU	Time Source
67028	XXX	1.44	**RUC Time**

CPT Descriptor intravitreal injection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 38.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 65800**	**Key Reference CPT Code:** 65430	**Source of Time** **RUC Time**
Median Pre-Service Time	18.00	10.00	
Median Intra-Service Time	5.00	10.00	
Median Immediate Post-service Time	5.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**28.00**	**28.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.38	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.62
Urgency of medical decision making	4.54	4.15
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.77	2.77
Physical effort required	3.31	2.85
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.08
Outcome depends on the skill and judgment of physician	3.92	3.38
Estimated risk of malpractice suit with poor outcome	3.69	3.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.85	3.46
Intra-Service intensity/complexity	3.38	2.92
Post-Service intensity/complexity	3.62	3.23

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT 65805 *Paracentesis of anterior chamber of eye (separate procedure); with **therapeutic release** of aqueous* was chosen for RUC review because it had a volume of > 30,000 and was Harvard valued. Prior to surveying the code, the consensus panel of the AAO reviewed two very similar codes CPT 65800 *Paracentesis of anterior chamber of eye (separate procedure); with **diagnostic aspiration** of aqueous* and 65805, with similar CPT descriptors. The panel felt

that the codes were essentially the same procedure (they also had the same WRVU) and that the descriptor terminology was dated. The volume of 65800 was also quite low. The decision was made to try to combine the two codes in a single descriptor using CPT 65800 with a slightly altered descriptor*: Paracentesis of Anterior Chamber of Eye (Separate Procedure); with removal of Aqueous*. This change was approved by CPT and the new code descriptor, which describes the removal of aqueous humor from the anterior chamber of the eye, was surveyed. The code is primarily used to remove intraocular fluid for culture as in the vignette or to decompress the eye if the pressure is too high.

There were 34 respondents (6.8% response rate) to the joint AAO survey and over 2/3 felt that the vignette was typical. The **25th percentile WRVU was 1.48** and the **median WRVU 1.53.** The median is 0.38 RVU less than the current value of the code (WRVU=1.91). The median times were 12.5 minutes pre, 5 minutes each positioning and scrub, dress and wait, 5 minutes IST and 10 minutes post-time. The predominant reference code chosen was CPT 65430 *Scraping of cornea, diagnostic, for smear and/or culture.* The code was RUC reviewed in 1995, is a 000 global, times of 10/10/8 and has **a WRVU of 1.47.** The surveyed code is not typically done with an E/M service.

The expert consensus panel of the AAO, which is familiar with the procedure and the RUC process, reviewed the results. The panel felt that pre-service package 6 (anesthesia is required for the procedure) was proper but removed 5 minutes to reflect the 12 minutes of time that our survey showed was typical for pre-service evaluation. We are recommending 18 minutes pre-time (12 evaluation, 1 position, 5 scrub dress wait), 5 minutes intra- and 5 minutes post- for a total time of 28 minutes.

The work of this code relates most closely in time and intensity to ocular injection codes. In this instance, a needle is placed through the cornea of the eye into the anterior chamber of the eye to remove rather than add material. The risks are the same as an intravitreal injection: bleeding, infection and damage to internal structures such as the iris or lens. These can all lead to rapid loss of vision. The survey respondents felt that the surveyed code was more intense and complex than the reference code, reflecting the fact that the reference code is an external rather than an intraocular procedure. The time for the reference code is longer because multiple scrapings are needed for smear and culture, but the work is of lower intensity.

There are several codes that are similar in work and intensity to 65800. CPT *67028 Intravitreal injection of a pharmacologic agent (separate procedure)* reviewed in 2009 has a WRVU of 1.44 with times of 12/5/5. Both involve penetration of the eye with a needle and the risk of damage to internal structures. The RUC felt that the work of 67028 was similar to that of CPT 67515 *Injection of medication or other substance into Tenon's capsule* (RUC 2005, 000, 11/5/5) which has a WRVU of 1.40. CPT *67500 Retrobulbar injection; medication (separate procedure, does not include supply of medication)* (RUC 2005, 000, 15/5/5) has similar times and intensities with a WRVU of 1.44. Both of these procedures involve extraocular injections. Because the risk of serious damage from an intraocular injection is greater than an extraocular injection, the panel felt that the value of 65800 should be slightly higher. The panel therefore recommends the median of the survey **WRVU 1.53** as the proper value for the procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) The patient is presenting with an infection and the 65800 service is used to remove aqeuous fluid and determine the causative organism in order to administer the appropriate treatment. That course of treatment is typically an injection (most typically intravitreal) of an antibiotic. The secondary injection is appended with the appropriate modifier.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your

scenario. CPT 67028 intravitreal injection -- XXX global, 1.44 wrvu, 12/5/5 for 22 minutes of time and appended with the --51 modifier

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FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 65800

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
39,058 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Combined utilization for 65800/65805

Specialty ophthalmology Frequency 39058 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 65800

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Paracentesis of the Eye

TAB: 21

						RVW						PRE-TIME			INTRA-TIME					IMMD
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	65430	Scraping of Cornea, diagnostic, for smear and/or culture	34	0.107			1.47			28	10					10			8
CURRENT	65800	paracentesis of anterior chamber of eye (separate procedure); with removal		0.094			1.91			44	11					13			20
SVY	65800	anterior chamber of eye (separate	34	0.175			1.53			37.5	12.5	5	5			5			10
REC				0.217			1.53			33	12	1	5			5			5

CPT Code: 65800
Specialty Society: AAO

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous

Global Period: **000** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The society convened a panel of experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: A**n existing code was revised to encompass two similar services and 65800 as well as 65805 should be compared**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The RN or tech completes the necessary referral forms from the facility where the procedure is to be performed. They then phone the facility to schedule the patient for the procedure. The informed consent provided by the physician is reiterated by the tech or RN who then assures that the appropriate forms are also signed by the patient.

Service Clinical Labor Activities:

Not applicable.

Post-Service Clinical Labor Activities:

Not applicable.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous

Global Period: **000** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The society convened a panel of experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: A**n existing code was revised to encompass two similar services and 65800 as well as 65805 should be compared.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The ophthalmic tech reiterates the informed consent provided by the physician and assures that the appropriate forms are signed by the patient.

Service Clinical Labor Activities:

The clinical staff confirms that all the medical records are available. The RN or ophthalmic tech then prepares the screening lane or room to ensure that all supplies and materials and equipment are available. Up to four slides are prepared with various media. The RN or tech greets the patient, confirms the treatment and correct side for treatment, provides appropriate gowning and obtains the necessary vital signs. The clinical staff will also review the injections site post-operatively and go over instructions. Once the physician has plated the fluid sample on the slide(s) for examination, the tech will take the slide(s) to the lab area for review or will phone the lab for pick up. The clinical staff cleans the lane after the patient is escorted to the administrative area.

Post-Service Clinical Labor Activities:

The RN or tech phones the patient to go over post-operative instructions regarding the treatment as well as to reiterate emergent post-operative side effects the patient should be aware of and reported to the office.

	A	B	C	D	E	F	G	H	I
1				OLD PE's				OLD PE's	
2				65800		65800		65805	
3	**Meeting Date: April 2012** **Tab:** **Specialty:Ophthalmology**	**CMS Code**	**Staff Type**	Paracentesis of ant. Chamber (separate); w/ diagnostic asp of aqueous		Paracentesis of ant. Chamber		Paracentesis of ant. Chamber (separate); w/therapeutic release of aqueous	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**0**	**0**	**0**	**0**	**0**	**0**
6	**TOTAL CLINICAL LABOR TIME**			**31.0**	**30.0**	**35.0**	**0.0**	**43.0**	**30.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**18.0**	**30.0**	**0.0**	**0.0**	**18.0**	**30.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**13.0**	**0.0**	**32.0**	**0.0**	**25.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST	**5**	**5**	**0**	**0**	**5**	**5**
13	Coordinate pre-surgery services	L038A	COMT/COT/RN/CST	**3**	**10**			**3**	**10**
14	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST		**5**		**0**		**5**
15	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST	**7**	**7**			**7**	**7**
16	Follow-up phone calls & prescriptions	L038A	COMT/COT/RN/CST	**3**	**3**			**3**	**3**
17	Other Clinical Activity - *specify:*								
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available	L038A	COMT/COT/RN/CST	**3**		**3**		**3**	
22	Obtain vital signs	L038A	COMT/COT/RN/CST	**3**		**3**		**3**	
23	Provide pre-service education/obtain consent					**3**			
24	Prepare room, equipment, supplies	L038A	COMT/COT/RN/CST	**2**		**2**		**2**	
25	Setup scope (non facility setting only)	L038A	COMT/COT/RN/CST						
26	Prepare and position patient/ monitor patient/ set up IV	L038A	COMT/COT/RN/CST	**2**		**2**		**2**	
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure	L038A	COMT/COT/RN/CST	**0**		**5**		**13**	
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff	L038A	COMT/COT/RN/CST	**2**		**3**		**2**	
33	Clean Scope								
34	Clean Surgical Instrument Package					**10**			
35	Complete diagnostic forms, lab & X-ray requisitions	L038A	COMT/COT/RN/CST	**1**		**1**			
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Other Clinical Activity - *specify:*								
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions					**3**			
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27						
49	99213 36 minutes		36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
1				OLD PE's				OLD PE's	
2				65800		65800		65805	
3	**Meeting Date: April 2012 Tab: Specialty:Ophthalmology**	**CMS Code**	**Staff Type**	Paracentesis of ant. Chamber (separate); w/ diagnostic asp of aqueous		Paracentesis of ant. Chamber		Paracentesis of ant. Chamber (separate); w/therapeutic release of aqueous	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**0**	**0**	**0**	**0**	**0**	**0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	Ophthalmology visit pack	SA050	pack	**1**		**1**		**1**	
57	Syringe, 5cc	91411		**1**				**1**	
58	Needle, 30 gauge	SC031		**1**		**1**		**1**	
59	Drape, plastic adhesive	SB010		**1**				**1**	
60	cellulose microsponges, (10/pack)		pack	**1**				**1**	
61	ballanced salt solution, 15-30 cc		bottle	**1**				**1**	
62	gloves, sterile, pr	SB024	pair			**1**			
63	syringe, TB	SC052				**1**			
64	Povodone swabsticks, 3/pack	SJ043	pack			**1**			
65	**EQUIPMENT**	**CODE**							
66	Lane, Screening	E71111		**1**		**21**		**1**	
67	Speculum, lid			**1**				**1**	
68	microscope, operating	EQ183		**1**				**1**	
69	pack, basic surgical	EQ137				**21**			
70	slide,glass, plain	SL238				**2**			
71	culture media	SL032				4			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Fourth Five-Year Review

September 2011

Biopsy of Eyelid

CMS identified CPT code 67810 *Incisional biopsy of eyelid skin including lid margin* as part of the 4th Five-Year Review of the RBRVS as Harvard-Valued - Utilization Over 30,000. In October 2010, the RUC referred code 67810 to the CPT Editorial Panel to expand the descriptor to include the "eyelid margin" as that was the intent, as well as clarify the vignette to also include the eyelid margin.

In September 2011, the RUC reviewed the survey results from 50 dermatologists and ophthalmologists for CPT code 67810 and determined that a decrease in the current work RVU to the survey 25th percentile work RVU of 1.18 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty society recommended pre-service time of 11 minutes and intra-service time of 13 minutes. The RUC acknowledged that the specialty society survey of 20 minutes and the standard of 23 minutes is too high due to the reporting of Evaluation and Management on the same date. The recommended pre-service time of 11 minutes addresses the issue. However, the RUC reduced the post-service time from 10 minutes to 5 minutes, as this service is typically performed with an Evaluation and Management service. The RUC compared 67810 to reference service 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)* (work RVU = 1.31) and determined that the surveyed service was more intense and complex as the biopsy surrounds the eye, however requires less physician time to perform than the reference service, 13 minutes versus 25 minutes, respectively. The RUC also compared 67810 to MPC codes 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10, total time = 30 minutes) and 62270 *Spinal puncture, lumbar, diagnostic* (work RVU = 1.37, total time = 40 minutes). Therefore, the survey 25th percentile work RVU of 1.18 and total physician time of 29 minutes appropriately accounts for the physician work required to perform this service relative to similar services. **The RUC recommends a work RVU of 1.18 for CPT code 67810.**

Practice Expense:
The PE Subcommittee reviewed the direct practice expense inputs recommended by the specialty and made modifications to the medical supplies and equipment time.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommenda-tion
▲67810	Incisional ~~B~~biopsy of eyelid skin including lid margin (For biopsy of skin of the eyelid, see 11100, 11101, 11310-11313)	000	1.18

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67810 Tracking Number Original Specialty Recommended RVU: **1.18**
Presented Recommended RVU: **1.18**
Global Period: 000 RUC Recommended RVU: **1.18**

CPT Descriptor: Incisional biopsy of eyelid skin including lid margin

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old female with new lesion at the eyelid margin. Malignancy is suspected

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prior to biopsy of lesion, obtain history related to the present procedure and photos are obtained. Discussion with patient will include: indication for biopsy procedure, risks, and benefits; description of biopsy procedure method, and expected result and/or scarring. The risks and complications of anesthesia such as ptosis and bruising reviewed with the patient. The preoperative interval history and exam are documented in the patient record. In addition, patient agreement/informed consent is obtained. Staff is advised to prepare patient and necessary anesthetic, supplies, and instrument tray is prepared and checked by physician.The head of the patient is positioned using a combination of rolled towels and/or temporary restraints, if needed. Staff is advised to prepare patient and necessary anesthetic, supplies, and instrument tray is prepared and checked by physician. The need for a regional field or nerve block is discussed, and administered as needed.

Nerve Block: Gloves are donned and the upper lip is retracted. Topical local anesthesia (5% lidocaine gel) is applied to the upper gingival sulcus. Three minutes are allowed to ensure topical anesthesia. The block is achieved with a #27 guage one-inch needle which is inserted just lateral to the upper second bicuspid at the gingival sulcus. The needle is advanced approximately 1.5 cm toward the infraorbital foramen in the mid-pupillary line. The syringe is aspirated to ensure that the tip of the needle is not in the infraorbital artery or vein, and 2 cc of 1% lidocaine is introduced taking care not to inject the infraorbital nerve directly. The needle is removed and gauze is applied to control bleeding at injection site. The nerve block takes approximately five minutes to take hold, at which time local anesthesia is instilled.

Should anesthesia be required for the upper eyelid, nerve block of the supraorbital and and infratrochlear nerve may be performed. Gloves are donned and a 27 guage one inch needle is inserted along the orbital rim at both the mid papillary line and medial brow. The syringe is aspirated to ensure that the tip of the needle is not in the supraorbital/infratrochelar artery or vein, and 1 cc of 1% lidocaine per site is introduced taking care not to inject the nerves directly. The needle is removed and gauze is applied to control bleeding at injection site. The nerve block takes approximately five minutes to take hold, at which time local anesthesia is instilled.

Description of Intra-Service Work: Inspection and palpation of the lesion to assess depth and to select most representative site to obtain specimen. The lesion is identified and a time out is performed. Cleanse biopsy site with suitable antiseptic. Local anesthesia is achieved using Lidocaine with epinephrine is drawn with a new needle infiltrated around the lesion for anesthesia and hemostasis. A drop of topical proparacaine is placed in the involved eye. Eye shield is inserted. Apply sterile drapes The lesion is sharply removed depending on depth and amount of tissue needed. Collect specimen in labeled formalin container. Hemostasis is achieved with cautery. Eye shield is removed. The adequacy of eyelid closure and blink are determined. Apply antibiotic ointment and sterile dressing.

Description of Post-Service Work: The specimen obtained is sent for pathologic analysis and necessary forms are completed. Post-service work includes: instruction of patient and/or family on postoperative wound care, dressing changes, and follow-up. Patient and family are again informed of the immediate side-effects and complications of anesthesia. Patient advised how to recognize significant complications, eg, bleeding, infection or allergic reaction to antibiotic ointment or adhesive dressings. Patient advised when results will be available and how they will be communicated; completion of medical record; and communication of results to referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Mark Kaufmann, MD/AAD, Brett Coldiron, MD/AAD, Fitzgeraldo Sanchez, MD/AAD and Steve Kamenetzky, M.D./AAO					
Specialty(s):	American Academy of Dermatology & American Academy of Ophthalmology					
CPT Code:	67810					
Sample Size:	200	**Resp N:**	50	**Response:** 25.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	18.00	**30.00**	110	300.00
Survey RVW:	0.70	1.18	**1.35**	1.60	3.10
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	2.00	10.00	**13.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	67810	**Recommended Physician Work RVU: 1.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**8.00**	**17.00**	**-9.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**2.00**	**5.00**	**-3.00**
Intra-Service Time:		**13.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11755	000	1.31	**RUC Time**

CPT Descriptor Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31231	000	1.10	**RUC Time**	361,190

CPT Descriptor 1 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
62270	000	1.37	**RUC Time**	78,069

CPT Descriptor 2 Spinal puncture, lumbar, diagnostic

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 32.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 67810**	**Key Reference CPT Code:** 11755	**Source of Time RUC Time**
Median Pre-Service Time	11.00	15.00	
Median Intra-Service Time	13.00	25.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**29.00**	**55.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.30
Urgency of medical decision making	3.46	3.23
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	3.25
Physical effort required	3.66	3.08
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.92	3.38
Outcome depends on the skill and judgment of physician	4.15	3.38
Estimated risk of malpractice suit with poor outcome	4.00	3.23

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.23	3.00
Intra-Service intensity/complexity	4.15	3.38
Post-Service intensity/complexity	3.30	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD) and the American Academy of Opthlalmology (AAO) have surveyed this code via random selection method as a pilot of the AMA RUC Survey capability. The data collected has been reviewed by the respective societies RUC Advisors and RBRVS committees. The survey data results do not meet any of the compelling evidence requirements. The societies propose accepting the 25th percentile of the survey data of 1.18 RVU and is presented here as their recommendation

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Per CMS data, performed on same day as an E&M service.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Dermatology Frequency 70000 Percentage 70.00 %

Specialty Ophthalmology Frequency 23000 Percentage 23.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50,277 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Data

Specialty Dermatology Frequency 34948 Percentage 69.51 %

Specialty Ophthalmology Frequency 11262 Percentage 22.39 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67810

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	A	B	C	D	E	F	G
1							
2	**Meeting Date: September 2011**			**67810**		**11311**	
3	**Specialty: AAD, AAO**			**Incisional biopsy of eyelid skin, including lid margin**		**Shaving of epidermal or dermal lesion, single lesion, face ears, eyelid, nose, lips, mucous memberane; lesion diameter 0.6 to 1.0 cm**	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**0**	**0**	**0**	**0**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**20**	**0**	**31**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**26**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L038A**	RN/LPN/MTA	**3**	**0**	**5**	**0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L038A**	RN/LPN/MTA	**0**	**0**	**0**	**0**
13	Coordinate pre-surgery services	**L038A**	RN/LPN/MTA	**0**	**0**	**0**	**0**
14	Schedule space and equipment in facility	**L038A**	RN/LPN/MTA	**0**	**0**	**0**	**0**
15	Provide pre-service education/obtain consent	**L038A**	RN/LPN/MTA	**0**	**0**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L038A**	RN/LPN/MTA	**0**	**0**	**0**	**0**
17	Other Clinical Activity:coordination of care	**L038A**	RN/LPN/MTA	**0**	**0**	**0**	**0**
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start:**						
21	Review charts	**L037D**	RN/LPN/MTA				
22	Greet patient and provide gowning	**L037D**	RN/LPN/MTA			**3**	
23	Obtain vital signs	**L037D**	RN/LPN/MTA			**2**	
24	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA			**3**	
25	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**		**2**	
26	Setup scope (non facility setting only)	**L037D**	RN/LPN/MTA				
27	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**		**2**	
28	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA				
29	**Intra-service**						
30	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**13**		**14**	
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA				
33	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**		**3**	
34	Clean Scope	**L037D**	RN/LPN/MTA				
35	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**10**			
36	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA				
37	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**2**		**2**	
39	Other Clinical Activity: follow-up phone call	**L037D**	RN/LPN/MTA				
40	**End: Patient leaves office**						
41	**POST-SERVICE Period**						
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions			**3**		**5**	
44	*Office visits:*						
45	*List Number and Level of Office Visits*						
46	99211 16 minutes		16	**0**	**0**	**0**	**0**
47	99212 27 minutes		27	**0**	**0**	**0**	**0**
48	99213 36 minutes		36	**0**	**0**	**0**	**0**
49	99214 53 minutes		53	**0**	**0**	**0**	**0**
50	99215 63 minutes		63	**0**	**0**	**0**	**0**
51	Other						
52	***Total Office Visit Time***	**L037D**	**RN/LPN/MTA**	**0**	**0**	**0**	**0**
53	***Other Total:***						
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**Code**	**Unit**				
56	pack, minimum multi-specialty visit	**SA048**	**pack**			**1**	
57	scalpel w blade, surgical (#10-20)	**SF033**		**1**		**1**	
58	cautery, bi-polar, pencil handpiece	**SF013**		**1**			
59	suture, nylon, 3-0 to 6-0, c	**SF036**		**1**			
60	suture, nylon, 4-0 to 6-0, c	**SF037**					
61	drape-towel, sterile 18 in x 26in	**SB019**		**4**			
62	drape, sterile barrier 16in x29in	**SB007**				**1**	
63	drape, sterile, fenestrated 16in x29in	**SB011**				**1**	
64	gloves, sterile	**SB024**		**2**		**2**	

	A	B	C	D	E	F	G
2	**Meeting Date: September 2011**			**67810**		**11311**	
3	**Specialty: AAD, AAO**			**Incisional biopsy of eyelid skin, including lid margin**		**Shaving of epidermal or dermal lesion, single lesion, face ears, eyelid, nose, lips, mucous memberane; lesion diameter 0.6 to 1.0 cm**	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
65	gown, staff, impervious	**SB027**		**1**		**1**	
66	skin marking pen	**SK 075**		**1**			
67	mask, surgical	**SB033**		**2**		**2**	
68	needle, 18-27g	**SC029**		**1**			
69	needle, 30g	**SC031**		**1**			
70	syringe-needle, 3ml, 22-26g	**SC064**		**1**		**1**	
71	hydrogen peroxide	**SJ028**		**1**		**1**	
72	povidine solution (Betadine)	**SJ041**		**10**		**10**	
73	dexamethasone 0.5% oph oint (4gm uou)	**SH027**		**1**		**0**	
74	bacitracin oint (0.9gm uou)	**SJ007**		**1**		**1**	
75	lidocaine 1% w-epi inj (xylocaine w epi)	**SH046**		**5**		**10**	
76	proparacaine	**SH058**		**1**			
77	water, sterile for irrigation (250-1000ml uou	**SH074**		**1**			
78	applicator, cotton-tipped, non sterile 6in	**SG008**		**20**			
79	eye pad, sterile, strabismus	**SG046**		**2**			
80	gauze, sterile 4in x 4in (10 pak uou)	**SG056**		**1**		**1**	
81	dressing, 12-7mm (Gelfoam)	**SG033**		**1**		**1**	
82	dressing, 3in x 4in (Telfa, Release)	**SG035**		**1**		**1**	
83	tape, surgical paper 1in (micropore)	**SG079**		**24**		**12**	
84	**Equipment**	**Code**					
85	table, power	**EF031**		**20**	**0**	**1**	**0**
86	light, surgical	**EF014**		**20**	**0**	**1**	**0**
87	instrument pack, medium	**EQ138**			0	0	0
88	instrument pack, basic	**EQ137**		1	0	1	0
89	Lane, Exam (Oph)	**EL005**				0	
90	electrocautery-hyfrecator, up to 45 watts	**EQ110**		1	0	0	0

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Low Value/High Volume Screen

January 2012

X-ray of Cervical Spine

In October 2010, cervical spine code 72040 was identified by the RAW as part of the CMS Low Value/High Volume screen. At the specialty societies' request, the cervical spine x-ray family of codes, CPT codes, 72040, 72050 and 72052, was referred to the CPT Editorial Panel for clarification of the descriptors and number of views. In October, 2011, the CPT Editorial Panel revised these codes to clarify the number of views for each examination. The ACR and ASNR surveyed these three codes, and convened an expert panel of physicians familiar with the services.

72040 *Radiologic examination, spine, cervical; three views or less* was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 43 radiologists and neuroradiologists on the expert panel and noted that the recommended RVU of 0.22, which is the current work RVU, appropriately accounts for the physician work required to perform this service. The RUC accepted the median survey times, but adjusted the pre-service time to 1 minute which is consistent with the chosen key reference code. The key reference CPT code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU=0.22), 6 minutes of total time (1 min pre, 3 min intra and 2 min post) was reviewed and the RUC noted that these two services have virtually identical physician work and should be the same. **The RUC recommends a work RVU of 0.22 for CPT code 72040.**

72050 *Radiologic examination, spine, cervical; 4 or 5 views* was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 42 radiologists and neuroradiologists on the expert panel and noted that the recommended RVU of 0.31, which is the current work RVU, appropriately accounts for the physician work required to perform this service. The RUC accepted the median survey times, but adjusted the pre-service time to 1 minute which is consistent with the chosen key reference code. The key reference CPT code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 view*s (work RVU=0.31) 8 minutes total time (1 min pre, 5 min intra, 2 min post) was reviewed and the RUC noted that these two services have virtually identical physician work and should be the same. **The RUC recommends a work RVU of 0.31 for CPT code 72050.**

72052 *Radiologic examination, spine, cervical; 6 or more views* was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 43 radiologists and neuroradiologists on the expert panel and noted that the recommended RVU of 0.36, which is the current work RVU, appropriately accounts for the physician work required to perform this service. The RUC accepted the median survey times, but adjusted the pre-service time to 1 minute which is consistent with the chosen key reference code. The key reference CPT code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views* (work RVU=0.32) 8 minutes total time (1 min pre, 5 min intra, 2 min post) was reviewed and the specialty society notified the RUC that the work value for 72114 was listed incorrectly as 0.36 on the survey that respondents completed. The RUC

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determined that the respondents were not biased by the inaccurate information and agrees with survey respondents whom consistently indicate that cervical spine examinations are more intense than those in the lumbar spine. To further justify the recommendation it is below the 25th percentile and the median and 25th percentile survey values were all higher than the corresponding services in the lumbar spine. The difference in intensity warrants the slightly higher RVU for 72052 as compared to its reference service 72114 and maintains proper relativity for this code as compared to the lumbar region. Specifically 72052 is typically performed on a patient complaining of pain or whom has had a fall in the outpatient setting. These patients are considered trauma patients even in the outpatient setting and they have a greater possibility of rotational injuries which are not a concern in the lumbar spine. **The RUC recommends a work RVU of 0.36 for CPT code 72052.**

Practice Expense:
The Practice Expense (PE) was reviewed by Practice Expense Subcommittee and it was determined that a laser printer is a indirect expense of a physicians' office and should not be listed as a direct input for practice expense. The modification was made and the RUC approved the PE for CPT codes 72040, 72050 and 72052.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Radiology** **Diagnostic Radiology (Diagnostic Imaging)** **Spine and Pelvis**				
▲72040	L1	Radiologic examination, spine, cervical; ~~2 or~~ 3 views or less	XXX	0.22 (No Change)
▲72050	L2	~~minimum of~~ 4 or 5 ~~or more~~ views	XXX	0.31 (No Change)
▲72052	L3	~~complete, including oblique and flexion and/or extension studies,~~ 6 or more views	XXX	0.36 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:72040 Tracking Number Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.22**
Global Period: XXX RUC Recommended RVU: **0.22**

CPT Descriptor: Radiologic examination, spine, cervical; three views or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Fifty-five-year-old female with cervical pain and no history of trauma. Rule out arthritis.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work:
- Supervise technologist performing the examination.
- Interpret radiographs of the cervical spine.
- Compare with prior studies, if applicable.
- Dictate report for medical record.

Description of Post-Service Work:
- Review, edit and sign final report.
- Discuss findings with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Joshua A. Hirsch, M.D., and Gregory Nicola, M.D.		
Specialty(s):	American College of Radiology and American Society of Neuroradiology		
CPT Code:	72040		
Sample Size: 830	**Resp N:** 43	**Response:** 5.1 %	
Sample Type: Panel	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	80.00	**150.00**	250.00	800.00
Survey RVW:	0.18	0.24	**0.25**	0.31	1.68
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	2.00	**3.00**	5.00	15.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	72040	**Recommended Physician Work RVU: 0.22**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**3.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
72100	XXX	0.22	**CMS Time File**

CPT Descriptor Radiologic examination, spine, lumbosacral; 2 or 3 views

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,560,976

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
72110	XXX	0.31	**Harvard Time**

CPT Descriptor Radiologic examination, spine, lumbosacral; minimum of 4 views

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 65.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 72040**	**Key Reference CPT Code:** 72100	**Source of Time** **CMS Time File**
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	3.00	3.00	
Median Immediate Post-service Time	2.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**6.00**	**6.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	1.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.93	1.85
Urgency of medical decision making	1.89	1.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.07	2.11
Physical effort required	1.63	1.59
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.11	2.00
Outcome depends on the skill and judgment of physician	2.70	2.59
Estimated risk of malpractice suit with poor outcome	2.52	2.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.41	1.37
Intra-Service intensity/complexity	2.11	2.11
Post-Service intensity/complexity	1.63	1.56

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

The three cervical spine x-ray codes: 72040 (*Radiologic examination, spine, cervical; three views or less), 72050 (Radiologic examination, spine, cervical; four or five or more views*), and 72052 (*Radiologic examination, spine, cervical; six or more views*) have been revised by the CPT Editorial Panel, clarifying the number of views for each examination.

The codes were initially captured by the CMS Low RVU-High Volume screen, and an action plan was submitted to the RAW (April 2011 RUC Meeting). At the societies' request, the family of codes was referred to the CPT Editorial Panel for clarification of the number of views, and to maintain consistency with the recently RUC-reviewed lumbar spine family of codes. The ACR and ASNR surveyed these three codes, and convened an expert panel of physicians familiar with the services.

The Reference Services were reviewed by the RUC in February 2011 and the societies' recommendations were accepted. However, there was an error in our Reference Service List provided to the respondents. The RUC should note that the RSL value for 72114 was listed as 0.36 RVU instead of the RUC-approved / CMS-accepted value of value of 0.32 RVU and that this code was chosen by the respondents as the reference service for 72052. There were no other errors in the RSL. We believe that the second most commonly chosen reference service 72110 with a value 0.31 RVU also serves as an adequate reference; however, it was chosen by only 19% of the respondents. The RUC should note that both the median and 25%tile values are higher than either reference service code and while one might argue that the respondents were biased at the median level, our recommendation is below the 25%tile and as such we do not believe the error created enough bias to invalidate the survey.

Work RVU Recommendation
We recommend maintaining the existing value of all three codes: 72040 - 0.22 RVU, 72050 - 0.31 RVU; 72052 - 0.36 RVU. The recommended values are lower than the survey median, but the societies find no compelling evidence supporting change in the work since the original valuation (72052) and/or RUC review in the First Five Year Review (72040 and 72050).

Pre, Intra, and Post Service Times
The societies are recommending the median survey times for all three codes. The societies recommend pre, intra, and post times of 1, 3, and 2 minutes, respectively for 72040 (three or less views); pre, intra, and post times of 1, 5, and 2 minutes, respectively for 72050 (four or five views); and pre, intra, and post times of 1, 5, and 2 minutes respectively for 72052 (six or more views). These times are consistent with the recently RUC-reviewed reference services and other plain radiography services.

Summary Of Recommendation
The societies' recommendations are supported by the most commonly chosen key reference services, 72100 (*Radiologic examination, spine, lumbosacral; 2 or 3 views)* with 0.22 RVU and 6 minutes of total time (1 min pre, 3 min intra and 2 min post), 72110 (*Radiologic examination, spine, lumbosacral; minimum of 4 views)* with 0.31 RVU and 8 minutes total time (1 min pre, 5 min intra, 2 min post) and 72114 (*Radiologic examination, spine, lumbosacral; complete, including bending views*) with 0.32 RVU and 8 minutes total time (1 min pre, 5 min intra, 2 min post),which were reviewed by the RUC in January 2011. The survey respondents consistently ranked examination of the cervical spine as more intense and complex than the reference lumbar spine services in all 11/11 intensity and complexity measures for 72050 and 72052 and 9/11 measures for 74040 which had 2 measures that were the same as the reference service. We believe this demonstrates the belief among the respondents that cervical spine examinations are more intense than those in the lumbar spine. The median and 25%tile survey values were all higher than the corresponding services in the lumbar spine. The difference in intensity and the slight increase in total time warrant the slightly higher RVU for 72052 as compared to its reference service 72114 and maintains proper relativity for this code as compared to the lumbar region.

The recommendation is also effectively bracketed by MPC code 71020 (*Radiologic examination, chest, 2 views, frontal and lateral*) with 0.22 RVU and 3 minutes of intra time on the lower end and MPC code 95900 (*Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study*) with 0.42 RVU and 6 minutes of intra time on the higher end. The recommended values fit appropriately within the rank order of other spine codes, as well as the entire family of plain radiography.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72040

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1722696
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 72040 in one year period is estimated to be 1,722,696.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 571,186 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data shows that code 72040 was billed approximately 571,186.

Specialty Diagnostic Radiology Frequency 93789 Percentage 16.42 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72040

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:72050 Tracking Number Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.31**
Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Radiologic examination, spine, cervical; four or five views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work:
- Supervise technologist performing the examination.
- Interpret radiographs of the cervical spine.
- Compare with prior studies, if applicable.
- Dictate report for medical record.

Description of Post-Service Work:
- Review, edit and sign final report.
- Discuss findings with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Joshua A. Hirsch, M.D. and Gregory Nicola, M.D.		
Specialty(s):	American College of Radiology and American Society of Neuroradiology		
CPT Code:	72050		
Sample Size: 830	**Resp N:** 42	**Response:** 5.0 %	
Sample Type: Panel	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	90.00	**150.00**	250.00	1200.00
Survey RVW:	0.25	0.32	**0.35**	0.38	1.88
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	3.00	**5.00**	6.00	17.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	72050	**Recommended Physician Work RVU: 0.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
72110	XXX	0.31	**Harvard Time**

CPT Descriptor Radiologic examination, spine, lumbosacral; minimum of 4 views

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,560,976

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
72114	XXX	0.32	**CMS Time File**

CPT Descriptor Radiologic examination, spine, lumbosacral; complete, including bending views

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 64.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 72050**	**Key Reference CPT Code:** 72110	**Source of Time Harvard Time**
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	2.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**8.00**	**8.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.46	2.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.38	2.31
Urgency of medical decision making	3.58	2.88
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.62	2.38
Physical effort required	1.96	1.85
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.38	2.73
Outcome depends on the skill and judgment of physician	3.38	3.04
Estimated risk of malpractice suit with poor outcome	4.19	3.46

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.65	1.58
Intra-Service intensity/complexity	3.00	2.65
Post-Service intensity/complexity	1.88	1.73

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

The three cervical spine x-ray codes: 72040 (*Radiologic examination, spine, cervical; three views or less), 72050 (Radiologic examination, spine, cervical; four or five or more views*), and 72052 (*Radiologic examination, spine, cervical;*

six or more views) have been revised by the CPT Editorial Panel, clarifying the number of views for each examination. The codes were initially captured by the CMS Low RVU-High Volume screen, and an action plan was submitted to the RAW (April 2011 RUC Meeting). At the societies' request, the family of codes was referred to the CPT Editorial Panel for clarification of the number of views, and to maintain consistency with the recently RUC-reviewed lumbar spine family of codes. The ACR and ASNR surveyed these three codes, and convened an expert panel of physicians familiar with the services.

The Reference Services were reviewed by the RUC in February 2011 and the societies' recommendations were accepted. However, there was an error in our Reference Service List provided to the respondents. The RUC should note that the RSL value for 72114 was listed as 0.36 RVU instead of the RUC-approved / CMS-accepted value of value of 0.32 RVU and that this code was chosen by the respondents as the reference service for 72052. There were no other errors in the RSL. We believe that the second most commonly chosen reference service 72110 with a value 0.31 RVU also serves as an adequate reference; however, it was chosen by only 19% of the respondents. The RUC should note that both the median and 25%tile values are higher than either reference service code and while one might argue that the respondents were biased at the median level, our recommendation is below the 25%tile and as such we do not believe the error created enough bias to invalidate the survey.

Work RVU Recommendation
We recommend maintaining the existing value of all three codes: 72040 - 0.22 RVU, 72050 - 0.31 RVU; 72052 - 0.36 RVU. The recommended values are lower than the survey median, but the societies find no compelling evidence supporting change in the work since the original valuation (72052) and/or RUC review in the First Five Year Review (72040 and 72050).

Pre, Intra, and Post Service Times
The societies are recommending the median survey times for all three codes. The societies recommend pre, intra, and post times of 1, 3, and 2 minutes, respectively for 72040 (three or less views); pre, intra, and post times of 1, 5, and 2 minutes, respectively for 72050 (four or five views); and pre, intra, and post times of 1, 5, and 2 minutes respectively for 72052 (six or more views). These times are consistent with the recently RUC-reviewed reference services and other plain radiography services.

Summary Of Recommendation
The societies' recommendations are supported by the most commonly chosen key reference services, 72100 (*Radiologic examination, spine, lumbosacral; 2 or 3 views)* with 0.22 RVU and 6 minutes of total time (1 min pre, 3 min intra and 2 min post), 72110 (*Radiologic examination, spine, lumbosacral; minimum of 4 views)* with 0.31 RVU and 8 minutes total time (1 min pre, 5 min intra, 2 min post) and 72114 (*Radiologic examination, spine, lumbosacral; complete, including bending views*) with 0.32 RVU and 8 minutes total time (1 min pre, 5 min intra, 2 min post),which were reviewed by the RUC in January 2011. The survey respondents consistently ranked examination of the cervical spine as more intense and complex than the reference lumbar spine services in all 11/11 intensity and complexity measures for 72050 and 72052 and 9/11 measures for 74040 which had 2 measures that were the same as the reference service. We believe this demonstrates the belief among the respondents that cervical spine examinations are more intense than those in the lumbar spine. The median and 25%tile survey values were all higher than the corresponding services in the lumbar spine. The difference in intensity and the slight increase in total time warrant the slightly higher RVU for 72052 as compared to its reference service 72114 and maintains proper relativity for this code as compared to the lumbar region.

The recommendation is also effectively bracketed by MPC code 71020 (*Radiologic examination, chest, 2 views, frontal and lateral*) with 0.22 RVU and 3 minutes of intra time on the lower end and MPC code 95900 (*Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study*) with 0.42 RVU and 6 minutes of intra time on the higher end. The recommended values fit appropriately within the rank order of other spine codes, as well as the entire family of plain radiography.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72050

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1381101
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 72050 in one year period is estimated to be 1,381,101.

Specialty Diagnostic Radiology Frequency 597049 Percentage 43.22 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 454,961 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that code 72050 was billed approximately 454,961.

Specialty Diagnostic Radiology Frequency 196180 Percentage 43.12 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72050

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:72052 Tracking Number Original Specialty Recommended RVU: **0.36**
Presented Recommended RVU: **0.36**
Global Period: XXX RUC Recommended RVU: **0.36**

CPT Descriptor: Radiologic examination, spine, cervical; six or more views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Forty-three-year-old male presents with trauma to the cervical spine from auto accident. Clinical concern for instability.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work:
- Supervise technologist performing the examination.
- Interpret radiographs of the cervical spine.
- Compare with prior studies, if applicable.
- Dictate report for medical record.

Description of Post-Service Work:

- Review, edit and sign final report.
- Discuss findings with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Joshua A. Hirsch, MD and Gregory Nicola, M.D.		
Specialty(s):	American College of Radiology and American Society of Neuroradiology		
CPT Code:	72052		
Sample Size:	830	**Resp N:** 43	**Response:** 5.1 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**100.00**	150.00	500.00
Survey RVW:	0.33	0.37	**0.40**	0.46	1.98
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	4.00	**5.00**	7.00	20.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	72052	**Recommended Physician Work RVU: 0.36**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
72114	XXX	0.32	**CMS Time File**

CPT Descriptor Radiologic examination, spine, lumbosacral; complete, including bending views

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,560,976

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
72110	XXX	0.31	**Harvard Time**

CPT Descriptor Radiologic examination, spine, lumbosacral; minimum of 4 views

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 81.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 72052**	**Key Reference CPT Code:** 72114	**Source of Time RUC Time**
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	2.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**8.00**	**8.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.79	2.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.85	2.65
Urgency of medical decision making	3.85	3.21
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.91	2.62
Physical effort required	2.03	2.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.71	2.97
Outcome depends on the skill and judgment of physician	3.59	3.24
Estimated risk of malpractice suit with poor outcome	4.18	3.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.88	1.82
Intra-Service intensity/complexity	3.44	3.15
Post-Service intensity/complexity	2.15	2.03

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

The three cervical spine x-ray codes: 72040 (*Radiologic examination, spine, cervical; three views or less), 72050 (Radiologic examination, spine, cervical; four or five or more views*), and 72052 (*Radiologic examination, spine, cervical; six or more views*) have been revised by the CPT Editorial Panel, clarifying the number of views for each examination. The codes were initially captured by the CMS Low RVU-High Volume screen, and an action plan was submitted to the

RAW (April 2011 RUC Meeting). At the societies' request, the family of codes was referred to the CPT Editorial Panel for clarification of the number of views, and to maintain consistency with the recently RUC-reviewed lumbar spine family of codes. The ACR and ASNR surveyed these three codes, and convened an expert panel of physicians familiar with the services.

The Reference Services were reviewed by the RUC in February 2011 and the societies' recommendations were accepted. However, there was an error in our Reference Service List provided to the respondents. The RUC should note that the RSL value for 72114 was listed as 0.36 RVU instead of the RUC-approved / CMS-accepted value of value of 0.32 RVU and that this code was chosen by the respondents as the reference service for 72052. There were no other errors in the RSL. We believe that the second most commonly chosen reference service 72110 with a value 0.31 RVU also serves as an adequate reference; however, it was chosen by only 19% of the respondents. The RUC should note that both the median and 25%tile values are higher than either reference service code and while one might argue that the respondents were biased at the median level, our recommendation is below the 25%tile and as such we do not believe the error created enough bias to invalidate the survey.

Work RVU Recommendation
We recommend maintaining the existing value of all three codes: 72040 - 0.22 RVU, 72050 - 0.31 RVU; 72052 - 0.36 RVU. The recommended values are lower than the survey median, but the societies find no compelling evidence supporting change in the work since the original valuation (72052) and/or RUC review in the First Five Year Review (72040 and 72050).

Pre, Intra, and Post Service Times
The societies are recommending the median survey times for all three codes. The societies recommend pre, intra, and post times of 1, 3, and 2 minutes, respectively for 72040 (three or less views); pre, intra, and post times of 1, 5, and 2 minutes, respectively for 72050 (four or five views); and pre, intra, and post times of 1, 5, and 2 minutes respectively for 72052 (six or more views). These times are consistent with the recently RUC-reviewed reference services and other plain radiography services.

Summary Of Recommendation
The societies' recommendations are supported by the most commonly chosen key reference services, 72100 (*Radiologic examination, spine, lumbosacral; 2 or 3 views)* with 0.22 RVU and 6 minutes of total time (1 min pre, 3 min intra and 2 min post), 72110 (*Radiologic examination, spine, lumbosacral; minimum of 4 views)* with 0.31 RVU and 8 minutes total time (1 min pre, 5 min intra, 2 min post) and 72114 (*Radiologic examination, spine, lumbosacral; complete, including bending views*) with 0.32 RVU and 8 minutes total time (1 min pre, 5 min intra, 2 min post),which were reviewed by the RUC in January 2011. The survey respondents consistently ranked examination of the cervical spine as more intense and complex than the reference lumbar spine services in all 11/11 intensity and complexity measures for 72050 and 72052 and 9/11 measures for 74040 which had 2 measures that were the same as the reference service. We believe this demonstrates the belief among the respondents that cervical spine examinations are more intense than those in the lumbar spine. The median and 25%tile survey values were all higher than the corresponding services in the lumbar spine. The difference in intensity and the slight increase in total time warrant the slightly higher RVU for 72052 as compared to its reference service 72114 and maintains proper relativity for this code as compared to the lumbar region.

The recommendation is also effectively bracketed by MPC code 71020 (*Radiologic examination, chest, 2 views, frontal and lateral*) with 0.22 RVU and 3 minutes of intra time on the lower end and MPC code 95900 (*Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study*) with 0.42 RVU and 6 minutes of intra time on the higher end. The recommended values fit appropriately within the rank order of other spine codes, as well as the entire family of plain radiography.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72052

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 292104
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 72052 in one year period is estimated to be 292,104.

Specialty Diagnostic Radiology Frequency 99140 Percentage 33.93 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 96,026 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that code 72052 was billed approximately 96,026.

Specialty Diagnostic Radiology Frequency 32736 Percentage 34.09 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72052

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: X-Ray Cervical Spine

TAB: 9

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF 1	72100	Radiologic examination, spine, lumbosa	28	0.051			0.22			6	1					3			2
CURRENT	72040	Radiologic examination, spine, cervical; 2 or 3		#DIV/0!			0.22			6									
SVY	72040	Radiologic examination, spine, cervical,	43	0.053	0.18	0.24	0.25	0.31	1.68	7	2			1	2	3	5	15	2
REC	72040			0.051			0.22			6	1					3			2

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF 1	72110	Radiologic examination, spine, lumbosa	27	0.049			0.31			8	1					5			2
CURRENT	72050	Radiologic examination, spine, cervical; minim		#DIV/0!			0.31			8									
SVY	72050	Radiologic examination, spine, cervical,	42	0.052	0.25	0.32	0.35	0.38	1.88	9	2			2	3	5	6	17	2
REC	72050			0.049			0.31			8	1					5			2

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF 1	72114	Radiologic examination, spine, lumbosa	35	0.051			0.32			9	1					5			2
CURRENT	72052	Radiologic examination, spine, cervical; compl		#DIV/0!			0.36			9									
SVY	72052	Radiologic examination, spine, cervical,	43	0.062	0.33	0.37	0.40	0.46	1.98	9	2			2	4	5	7	20	2
REC	72052			0.059			0.36			8	1					5			2

CPT Code: 72040, 72050, & 72052
Specialty Society('s) ACR and ASNR

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
72040 - Radiologic examination, spine, cervical, three views or less
72050 - Radiologic examination, spine, cervical, four or five views
72052 - Radiologic examination, spine, cervical, six or more views

Global Period: XXX Meeting Date: 01/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

American College of Radiology and American Society of Neuroradiology convened consensus panel to finalize the practice expense data for codes 72040, 72050 and 72052.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning, ensure appropriate medical records are available
- Prepare room, equipment, supplies
- Prepare and position patient/monitor patient/set up IV
- Assist physician in performing procedure/Acquire Images
- Clean room, equipment by physician staff
- Process films, hang films and review study with interpreting MD prior to patient discharge

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I
1	**Tab 9: Revised**								
2				**72040**	**72040**	**72050**	**72050**	**72052**	**72052**
3	**Meeting Date: Jan 2012** **Specialty:ACR and ASNR**	**CMS**	**Staff**	**Radiologic examination, spine, cervical; two or three views** **PEAC approved Aug 2003**	**Radiologic examination, spine, cervical, three views or less** **Jan 2012**	**Radiologic examination, spine, cervical; minimum of four views** **PEAC approved Aug 2003**	**Radiologic examination, spine, cervical, four or five views** **Jan 2012**	**Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies** **PEAC approved Aug 2003**	**Radiologic examination, spine, cervical, six or more views** **Jan 2012**
4	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**	**Non Facility**	**Non Facility**	**Non Facility**
5	**GLOBAL PERIOD**			**xxx**	xxx	xxx	xxx	xxx	xxx
6	**TOTAL CLINICAL LABOR TIME**	**LO41B**	**RT**	**20.0**	**20.0**	**28.0**	**28.0**	**36.0**	**36.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**LO41B**	**RT**	**20.0**	**20.0**	**28.0**	**28.0**	**36.0**	**36.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**SERVICE PERIOD**								
12	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
13	Greet patient, provide gowning, ensure appropriate medical records are available	LO41B	RT	3	3	3	3	3	3
14	Obtain vital signs								
15	Provide pre-service education/obtain consent								
16	Prepare room, equipment, supplies	LO41B	RT	1	1	1	1	1	1
17	Setup scope (non facility setting only)								
18	Prepare and position patient/ monitor patient/ set up IV	LO41B	RT	1	1	1	1	1	1
19	Sedate/apply anesthesia								
20	**Intra-service**								
21	Assist physician in performing procedure/ Acquire images	LO41B	RT	9	9	15	15	21	21
22	**Post-Service**								
23	Monitor pt. following service/check tubes, monitors, drains								
24	Clean room/equipment by physician staff	LO41B	RT	2	2	2	2	2	2
25	Clean Scope								
26	Clean Surgical Instrument Package								
27	Complete diagnostic forms, lab & X-ray requisitions								
28	Review/read X-ray, lab, and pathology reports								
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
30	Discharge day management								
31	Other Clinical Activity (please specify): Follow up phone call								
32	*- Process films, hang films and review study with interpreting MD prior to patient discharge*	LO41B	RT	4	4	6	6	8	8
33	**End: Patient leaves office**								
34	**POST-SERVICE Period**								
35	**MEDICAL SUPPLIES**		**Unit**						
36	Film developer/cost per exposure	SK089		3	3	5	5	7	7
37	Film jacket or jacket insert			1	1	1	1	1	1
38	Film, 10x12	SK033		3	3	5	5	7	7
39	Film, 14x17	SK034							
40	Film, 14x36	SK035							
41	Film fixer	SK092		3	3	5	5	7	7
42	Patient gown, disposable	SB026		1	1	1	1	1	1
43									
44									
45	**Equipment**								
46	Radiology room (min)	EL012		1	20 min	1	28 min	1	36 min
47	Film alternator (motorized film viewbox)	ER029		1	20 min	1	28 min	1	36 min
48	Film processor, wet	ED025		1	20 min	1	28 min	1	36 min

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization over 30,000

April 2012

Thyroid Uptake/Imaging

In April 2011 CPT Code 78007, *Thyroid imaging, with uptake; multiple determinations* was identified in the Harvard Valued-Utilization over 30,000 screen. In February 2012, the CPT Editorial Panel approved a plan to consolidate seven thyroid codes into three new CPT codes.

78012 ***Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed)***
The RUC reviewed the survey results of 118 respondents and determined that the survey respondents overestimated the physician work involved in this service. The RUC agreed with the specialty that the 25th percentile in intra-service time of 5 minutes was a more accurate depiction of the work involved. The RUC also noted that the survey's work values were overestimated and agreed that a work RVU of 0.19 which is below the 25th percentile is appropriate. This procedure is currently reported using CPT codes 78000 *Thyroid uptake; single determination* (work RVU=0.19), 78001 *Thyroid uptake; multiple determinations* (work RVU=0.33) and 78003 *Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)* (work RVU=0.33) and will be bundled into 78012. The RUC agreed with the specialty that the work value of 78012 is identical to the physician work of CPT 78000 and should have an identical work RVU of 0.19. The RUC compared 78012 to key reference service 78226 *Hepatobiliary system imaging, including gallbladder when present* (work RVU=0.74) and determined 78226 requires more time and intensity and should therefore be valued higher. The RUC also reviewed CPT Code 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU=0.17) and 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (work RVU=0.22) and agreed that 78012 should be valued between these two services. **The RUC recommends a work RVU of 0.19 for CPT code 78012.**

78013 ***Thyroid imaging (including vascular flow, when performed)***
The RUC reviewed the survey results of 113 respondents and determined that the survey respondents overestimated the physician work involved in this service. The RUC agreed with the specialty that the 25th percentile intra-service time of 10 minutes was a more accurate depiction of the time involved and maintains rank order with the family of services. The RUC also noted that the survey's work values were overestimated and agreed that a work RVU of 0.37, which is below the 25th percentile, is more appropriate. This procedure is currently reported using CPT codes 78010 *Thyroid imaging; only* (work RVU=0.39) and 78011 *Thyroid imaging; with vascular flow* (work RVU=0.45). The RUC agreed that the valuation of 78013 should be based on the most commonly reported current code, 78010; however the RUC made slight adjustments to preserve work neutrality across the family. Therefore, a work RVU of 0.37 for 78013 is relative to the family of services. The RUC compared 78013 to key reference service 78226 *Hepatobiliary system imaging, including gallbladder when present* (work RVU=0.74) and agreed that although the times are the same, the intensity of 78226 is higher. The RUC also reviewed 77071 *Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated* (work RVU=0.41) and determined that although 78013 has more physician time, the

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intensity of 77071 is greater and should therefore be valued slightly higher. The RUC agreed that a work RVU of 0.37 would maintain proper rank order and budget neutrality within this family of service. **The RUC recommends a work RVU of 0.37 for CPT code 78013.**

78014 ***Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed)***

The RUC reviewed the survey results of 129 respondents and determined that the survey respondents overestimated the physician work involved in this service. The RUC agreed with the specialty that in order to maintain rank order within the family of services the intra-service time should be crosswalked to 78013, 10 minutes. The RUC also noted that the survey's work values were overestimated and agreed that a work RVU of 0.50, which is below the 25th percentile, is more appropriate. This procedure is currently reported using CPT codes 78006 *Thyroid imaging, with uptake; single determination* (work RVU=0.49) and 78007 *Thyroid imaging, with uptake; multiple determinations* (RVU=0.50) and will be bundled into 78014. The RUC agreed with the specialty that no compelling evidence for an increase exists. As such, the work value of 78014 should be equivalent to the most commonly reported service currently, CPT 78007 and should have an identical work RVU of 0.50. The RUC compared 78014 to code 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU=0.90) and determined that 78227 has a higher work intensity and requires more physician time. The RUC also reviewed CPT codes 77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician* (work RVU=0.62) and 78306 *Bone and/or joint imaging; whole body* (work RVU=0.86) and determined that although these services require similar physician work, the intensity of 77300 and 78306 is higher. Finally, the RUC compared 78014 to 78013 and noted that while the physician time is the same, 78014 should be valued higher because it has greater intensity and complexity since it includes the work of 78012 and 78013. The RUC determined that a work RVU of 0.50 maintains proper rank order and budget neutrality within this family of services. **The RUC recommends a work RVU of 0.50 for CPT Code 78014.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D78000		~~Thyroid uptake; single determination~~	XXX	N/A
D78001		~~multiple determinations~~	XXX	N/A
D78003		~~stimulation, suppression or discharge (not including initial uptake studies)~~	XXX	N/A
D78006		~~Thyroid imaging, with uptake; single determination~~	XXX	N/A
D78007		~~multiple determinations~~	XXX	N/A
D78010		~~Thyroid imaging; only~~	XXX	N/A
D78011		~~with vascular flow~~ (78000-78011 have been deleted. To report, see 78012-78014)	XXX	N/A
● 78012	T1	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed)	XXX	0.19

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● 78013	T2	Thyroid imaging (including vascular flow, when performed);	XXX	0.37
● 78014	T3	with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed)	XXX	0.50

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78012 Tracking Number T1 Original Specialty Recommended RVU: **0.19**
Presented Recommended RVU: **0.19**
Global Period: XXX RUC Recommended RVU: **0.19**

CPT Descriptor: Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old woman with clinical symptoms of hyperthyroidism, blood thyroid function tests indicative of hyperthyroidism, and a diffusely enlarged non-nodular thyroid gland on physical examination.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including available prior imaging studies and determines the appropriateness of the requested study; prescribes, oversees and directs the oral administration of the radiopharmaceutical dose.

Description of Intra-Service Work: The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure
The study typically consists of a single 24 hour uptake and at times multiple measurements at early 4 to 6 hours plus the typical 24 hours are collected. A second standard capsule is maintained for comparison measurements. The patient should sit or lie with neck extended; an open-faced collimated detector probe should be directed at the neck. Counts of the patient neck and mid-thigh are obtained and repeated at varying time intervals as necessary. The physician verifies the adequacy of the data before completion of the study, and directs the technologist to obtain counts or re-process data, when necessary.
The measurements are compared to relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician provides mandatory NRC regulatory review and oversight of the radiopharmaceutical throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; Kenneth McKusick, MD; Gary Dillehay, MD; Scott C. Bartley, MD		
Specialty(s):	Society of Nuclear Medicine, American College of Radiology, and American College of Nuclear Medicine		
CPT Code:	78012		
Sample Size:	2954	**Resp N:** 118	**Response:** 3.9 %
Description of Sample:	A survey was randomly sent to ACNM, SNM and ACR members. There were 118 responses to the survey.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	100.00	675.00
Survey RVW:	0.15	0.60	**0.85**	1.00	51.80
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**10.00**	15.00	40.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	78012	**Recommended Physician Work RVU: 0.19**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78226	XXX	0.74	**RUC Time**

CPT Descriptor Hepatobiliary system imaging, including gallbladder when present;

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73560	XXX	0.17	**RUC Time**	2,120,952

CPT Descriptor 1 Radiologic examination, knee; 1 or 2 views

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,329,285

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 20.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 78012**	**Key Reference CPT Code:** 78226	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.63	2.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.70
Urgency of medical decision making	2.17	2.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.38	2.38
Physical effort required	1.70	1.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.96	2.42
Outcome depends on the skill and judgment of physician	2.79	2.79
Estimated risk of malpractice suit with poor outcome	1.83	2.54

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.35	2.04
Intra-Service intensity/complexity	2.61	2.78
Post-Service intensity/complexity	2.04	1.92

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78007 *(Thyroid imaging, with uptake; multiple determinations)* was identified as a potentially misvalued code through the Harvard-valued, volume greater than 30,000 utilization screen. The joint societies, ACNM, SNM and ACR, presented an action plan to revise the thyroid family CPT 78000 to 78010 in the Nuclear Medicine section under the Endocrine System in CPT, stating this section would greatly benefit from revisions to modernize and consolidate the codes

prior to performing an AMA RUC survey. The pre-revision CPT codes representing the thyroid family consisted of seven codes: three for uptakes only, two for uptakes with imaging, and two for imaging only. The new thyroid family of codes was consolidated from these seven CPT codes into three CPT codes for simplicity and grouping by the major resource similarities.

78012 Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed)

78012 is a new code describing uptake-only procedures, where the typical and most common procedure based on the Medicare data base and our expert panel is a ***single thyroid uptake measurement.*** The difference in physician work for performance of a single uptake versus multiple uptakes is minimal; therefore, the panel felt it was appropriate to represent both procedures as a single procedure code. Suppression, discharge and stimulation uptake studies are rare, as evidenced by the Medicare claims data for 2010 of 78003 at 19 in total; and supported by the multisociety expert panel, again warranting a consolidation of the three codes into a single multi-procedure CPT code. Based on the 2010 data in which 78000 is the more common service, we considered single thyroid uptake to be typical for the purposes of the survey. Ninety-seven percent of the survey respondents stated that the vignette was typical.

A joint ACNM, SNM and ACR RVS panel (ACNM/SNM/ACR) reviewed the survey results. There were 118 responses to the survey request. The survey performance rate median of 50 studies per year among the 118 respondents is a reasonable rate given this is a relatively low volume procedure. The panel agreed that the survey physician median times of 5 minutes pre-service, 5 minutes post-service accurately reflect the time required to perform this service. Therefore, we selected pre-service XXX global package and adjusted the time to our recommended value of 5 minutes. We believe the survey median 10 minutes intra-service time is excessive for a single uptake study; therefore, we recommend reducing the intra time to the 25 percentile time of 5 minutes.

The panel felt that the median and 25th percentile RVW appropriately capture the relativity between the procedures in the family; however, the values from this family did not correlate well with RVW values of other nuclear medicine code families that have been RUC and CMS valued. The crosswalk current CPT codes 78000 (RVW-0.19) 78001 (RVW-0.26) and 78003 (RVW-0.33) will now be reported with code (78012). The ACNM/SNM/ACR panel discussed at length compelling evidence arguments to support the survey median or 25th percentile results. The ACNM/SNM/ACR panel believed that the original Harvard value had likely undervalued this procedure. However, the reason for the current change in coding was to better describe the services and simplify the coding structure for these low volume procedures. These codes were surveyed in response to the RAW request, but we believe these procedures have not fundamentally changed over the years. As there was insufficient compelling evidence for higher values for 78012 or the whole family of thyroid codes, we are recommending to maintain the current RVWs of the highest volume crosswalked CPT code for valuation (78000 - .19 RVW). We continue to urge the RUC to accept "Harvard valued" as a criterion for compelling evidence, which we believe would apply to CPT 78012 and which we believe our survey data supports.

We believe the reference service code chosen by the survey respondents, CPT 78226 (*Hepatobiliary system imaging, including gallbladder when present);* (RVW 0.74) has higher work intensity and complexity than 78012, with 78226 having a longer intra-service time of 10 minutes and being ranked higher on the intensity factors for medical decision making, risk of significant complications and risk of malpractice.

We compared 78012 to MPC code CPT 73560 (*Radiologic examination, knee; 1 or 2 views),* (RVW 0.17). While we believe these procedures are comparable in intensity and complexity, the panel would agree that 78012 should be valued slightly higher (RVW 0.19) than 73560 and slightly lower than CPT 71020 (*Radiologic examination, chest, 2 views, frontal and lateral*) (RVW 0.22).

In summary, to maintain rank order and remain within budget neutrality we recommend a RVW of 0.19 for 78012with a pre service time of 5 minutes, an intra service time of 5 minutes, and post time of 5 minutes, for a total time of 15 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 78000, 78001, 78003

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7653
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 780X01 might be provided 7,653 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 2074 Percentage 27.10 %

Specialty Nuclear Medicine Frequency 613 Percentage 8.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,551
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Codes 78000, 78001, and 78003 are currently used to report the procedure described by 780X01. The 2010 Medicare frequency for code 78000 is 1,402, the frequency for 78001 is 1,130, and the frequency for 78003 is 19. To calculate the frequency for code 780X01, we summed the frequencies for the three codes to get 2,551. Then, multiply the frequency for each code, 78000, 78001, and 78003, by the appropriate frequency (percent) for each specialty, Diagnostic Radiology or Nuclear Medicine, to estimate the number of times the specialty might provide the service described by 78012 to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 691 Percentage 27.08 %

Specialty Nuclear Medicine Frequency 204 Percentage 7.99 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 78000

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78013 Tracking Number T2 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: Thyroid imaging (including vascular flow, when performed);

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman with two thyroid nodules on physical examination, without clinical symptoms of hyperthyroidism and with blood thyroid function tests indicative of euthyroidism.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 8%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including available prior imaging studies and determines the appropriateness of the requested study; prescribes, oversees and directs the oral administration of the radiopharmaceutical dose.

Description of Intra-Service Work: The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.
Thyroid scintigraphy facilitates the detection of focal and/or global abnormalities of thyroid anatomy, correlation of anatomy with function, and detection of aberrant or residual normal tissue after therapy. Under the supervision of the physician, the technologist administers the radiopharmaceutical following the protocol determined. The complete study consists of administration of the radiopharmaceutical by oral or typically by intravenous injection, acquisition of multiple images in a variety of projections, and documentation of patient position. Radioactive sources or lead markers may be used to identify anatomic landmarks such as the sternal notch and thyroid cartilage. When appropriate, the location of palpable nodules should be confirmed with radioactive point source or lead marker image for anatomic correlation. The physician palpates and localizes any palpable nodules. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data, when necessary.
The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The raw images (eg, upright or supine, anterior, obliques, etc.) of the imaging are compared to any additional relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record. The data are formatted for film and/or digital display and analysis.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. Imaging data is normally reviewed with the referring physician when surgery is anticipated and may be discussed with the patient. The physician provides mandatory NRC regulatory review and oversight of the radiopharmaceutical throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; Kenneth McKusick, MD; Gary Dillehay, MD; Scott C. Bartley, MD		
Specialty(s):	Society of Nuclear Medicine, American College of Radiology, and American College of Nuclear Medicine		
CPT Code:	78013		
Sample Size:	2954	**Resp N:** 113	**Response:** 3.8 %
Description of Sample:	A survey was randomly sent to ACNM, SNM and ACR members. There were 113 responses.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**40.00**	100.00	1000.00
Survey RVW:	0.30	0.75	**0.90**	1.05	37.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**12.00**	20.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	78013	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78226	XXX	0.74	**RUC Time**

CPT Descriptor Hepatobiliary system imaging, including gallbladder when present;

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,056,063

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 22.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 78013**	**Key Reference CPT Code:** 78226	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.84	2.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.00
Urgency of medical decision making	1.92	3.12
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.92	2.84
Physical effort required	1.80	1.76
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.16	2.64
Outcome depends on the skill and judgment of physician	3.08	3.04
Estimated risk of malpractice suit with poor outcome	2.04	2.76

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.40	2.44
Intra-Service intensity/complexity	2.80	2.96
Post-Service intensity/complexity	2.16	2.28

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78007 *(Thyroid imaging, with uptake; multiple determinations)* was identified as a potentially misvalued code through the Harvard-valued, volume greater than 30,000 utilization screen. The joint societies, ACNM, SNM and ACR, presented an action plan to revise the thyroid family CPT 78000 to 78010 in the Nuclear Medicine section under the Endocrine System in CPT, stating this section would greatly benefit from revisions to modernize and consolidate the codes prior to performing an AMA RUC survey. The pre-revision CPT codes representing the thyroid family consisted of seven codes: three for uptakes only, two for uptakes with imaging, and two for imaging only. The new thyroid family of codes was consolidated from these seven CPT codes into three CPT codes for simplicity and grouping by the major resource similarities.

78013 Thyroid imaging (including vascular flow, when performed);
78013 is a new code describing thyroid imaging-only procedures, where the typical and most common procedure based on Medicare data and based on our expert panel is a ***thyroid imaging study without vascular flow.*** The difference in physician work necessary for performing a thyroid imaging study *with flow* versus *without flow* is minimal; therefore, the panel felt it was appropriate to represent both procedures as a single procedure code. Thyroid imaging studies with vascular flow are rare as evidenced by the Medicare claims data for 2010 at 188 in total, and supported by the multisociety expert panel, again warranting a consolidation of the two codes into a single multi-procedure CPT code. Based on the 2010 data in which 78010 is the more common service, we considered thyroid imaging without vascular flow to be typical for the purposes of the survey. Eighty-nine percent of the survey respondents stated that the vignette was typical.
A joint ACNM, SNM and ACR RVS panel (ACNM/SNM/ACR) reviewed and discussed the survey results. There were 113 responses to the survey request. The survey performance rate median of 40 studies per year among the 113 respondents is a reasonable rate given this is a relatively low volume procedure. The panel agreed that the survey physician median times of 5 minutes pre-service and 5 minutes post-service accurately reflect the time required to perform this service. The panel recommends pre-service package XXX. We believe the survey median of 12 minutes intra-service time is excessive for a thyroid imaging only study; therefore, we recommend reducing the intra time to the 25 percentile time of 10 minutes.

The panel felt that the median and 25th percentile RVW appropriately capture the relativity between the procedures in the family; however, the values from this family did not correlate well with RVWs of other nuclear medicine code families that have been RUC and CMS valued. The crosswalk current CPT codes 78010 (RVW-0.39) and 78011 (RVW-0.45) will now be reported as code 78013. The panel discussed at length compelling evidence arguments to support the survey median or 25th percentile results. The panel believed that the original Harvard value had likely undervalued this procedure. However, the reason for the current change in coding was to better describe the services and simplify the coding structure for low volume procedures. These codes were surveyed in response to the RAW request, but we believe these procedures have not fundamentally changed over the years. As there was insufficient compelling evidence for higher values for 78013 or the whole family of thyroid codes, we are basing our recommendation on the current RVWs of the highest volume crosswalked CPT code for valuation (78010 - .39 RVWs). We recommend subtracting .02 RVWs to preserve budget neutrality across the thyroid family. Therefore, our RVW recommendation for 78013 is .37 RVW. We continue to urge the RUC to accept "Harvard valued" as a criterion for compelling evidence, which we believe would apply to CPT 78013 and which we believe our survey data supports.

We believe the reference service code chosen by the survey respondents, CPT 78226 (*Hepatobiliary system imaging, including gallbladder when present);* (RVW 0.74) has higher work intensity and complexity than 78013, with 78226 having a longer intra-service time of 10 minutes and being ranked higher on the intensity factors for medical decision making, risk of significant complications and risk of malpractice.

We compared 78013 to a MPC code CPT 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family),* (RVW 0.48). While we believe these procedures are comparable in intensity and complexity the panel agreed that 78013 should be valued lower (RVW 0.37) than both MPC codes 99212 and CPT 77300 (*Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician*), (RVW 0.62).
In summary, to maintain rank order and remain within budget neutrality we recommend a RVW of 0.37 for 78013with a pre service time of 5 minutes, an intra service time of 10 minutes, and post time of 5 minutes, for a total time of 20 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 78010, 78011

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 19776
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 78013 might be provided 19,776 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 6020 Percentage 30.44 %

Specialty Nuclear Medicine Frequency 3427 Percentage 17.32 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,592
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Codes 78010 and 78011 are currently used to report the procedure described by 78013. The 2010 Medicare frequency for code 78010 is 6,404 and the frequency for 78011 is 188. To calculate the frequency for code 78013, we summed the frequencies for the two codes to get 6,592.

Then, multiply the frequency for each code, 78010 and 78011, by the appropriate frequency (percent) for each specialty, Diagnostic Radiology or Nuclear Medicine, to estimate the number of times the specialty might provide the service described by 78013 to Medicare patients nationally in a one-year period

Specialty Diagnostic Radiology Frequency 2007 Percentage 30.44 %

Specialty Nuclear Medicine Frequency 1142 Percentage 17.32 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 78010

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78014 Tracking Number T3 Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old woman with clinical symptoms of hyperthyroidism, blood thyroid function tests indicative of hyperthyroidism, and a multi-nodular goiter on physical examination.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 5%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including available prior imaging studies and determines the appropriateness of the requested study; prescribes, oversees and directs the oral administration of the radiopharmaceutical dose.

Description of Intra-Service Work: Thyroid imaging with single or typically multiple uptakes is a combination of two radionuclide diagnostic imaging procedures that record both the detection of focal and/or global abnormalities of thyroid anatomy, correlation of anatomy with function, and detection of aberrant or residual normal tissue after therapy. Under the supervision of the physician, the technologist administers the radiopharmaceutical(s) following the protocol determined. The complete study consists of administration of the radiopharmaceutical(s) typically by oral or at times by intravenous injection, acquisition of multiple images in a variety of projections, and documentation of patient position. Radioactive sources or lead markers may be used to identify anatomic landmarks such as the sternal notch and thyroid cartilage. When appropriate, the location of palpable nodules should be confirmed with radioactive point source or lead marker image for anatomic correlation. The physician palpates and localizes any palpable nodules. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data, when necessary.
The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The raw images (eg, upright or supine, anterior, obliques, etc.) of the imaging are compared to any additional relevant prior studies, as well as the single or multiple uptakes. The data are formatted for film and/or digital display and analysis. Additionally single or typically multiple measurements at early 4 to 6 hours and or 24 hours are collected.
The patient should sit or lie with neck extended; an open-faced collimated detector probe should be directed at the neck. The study consists of single or typically multiple counts of the patient neck and mid-thigh, repeated at varying time

intervals as necessary. A second standard capsule is maintained for comparison measurements. The physician verifies the adequacy of the data before completion of the study, and directs the technologist to obtain counts additional imaging or re-process data, when necessary. The quantitative evaluations of measurements are compared to relevant prior and current studies, and formally interpreted, i.e., a report is dictated for the medical record.
The physician verifies the adequacy of the data before completion of the study, and directs the technologist to obtain counts or re-process data, when necessary. The measurements are compared to relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. Imaging data is normally reviewed with the referring physician when surgery is anticipated and may be discussed with the patient. The physician provides mandatory NRC regulatory review and oversight of the radiopharmaceutical throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; Kenneth McKusick, MD; Gary Dillehay, MD; Scott C. Bartley, MD		
Specialty(s):	Society of Nuclear Medicine, American College of Radiology, and American College of Nuclear Medicine		
CPT Code:	78014		
Sample Size:	2954	**Resp N:** 129	**Response:** 4.3 %
Description of Sample:	A survey was randomly sent to ACNM, SNM and ACR members. There were 129 responses.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	30.00	**70.00**	112.00	1000.00
Survey RVW:	0.48	0.90	**1.00**	1.23	37.00
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	8.00	**15.00**	20.00	55.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	78014	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78227	XXX	0.90	**RUC Time**

CPT Descriptor Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78306	XXX	0.86	**RUC Time**	412,804

CPT Descriptor 2 Bone and/or joint imaging; whole body

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 18.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 78014**	**Key Reference CPT Code:** 78227	**Source of Time RUC Time**
Median Pre-Service Time	5.00	6.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**26.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.04	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	3.00
Urgency of medical decision making	2.13	2.78
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.74	2.73
Physical effort required	2.43	2.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.29	2.70
Outcome depends on the skill and judgment of physician	3.25	3.04
Estimated risk of malpractice suit with poor outcome	2.17	2.30

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.43	2.36
Intra-Service intensity/complexity	3.09	3.17
Post-Service intensity/complexity	2.33	2.33

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78007 *(Thyroid imaging, with uptake; multiple determinations)* was identified as a potentially misvalued

code through the Harvard-valued, volume greater than 30,000 utilization screen. The joint societies, ACNM, SNM and ACR, presented an action plan to revise the thyroid family CPT 78000 to 78010 in the Nuclear Medicine section under the Endocrine System in CPT, stating this section would greatly benefit from revisions to modernize and consolidate the codes prior to performing an AMA RUC survey. The pre-revision CPT codes representing the thyroid family consisted of seven codes: three for uptakes only, two for uptakes with imaging, and two for imaging only. The new thyroid family of codes was consolidated from these seven CPT codes into three CPT codes for simplicity and grouping by the major resource similarities.

78014 Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed)

78014 is a new code describing thyroid uptake plus imaging procedures, where the typical and most common procedure based on Medicare data and based on our expert panel is a ***thyroid imaging plus multiple uptake measurements.*** The difference in physician work necessary for performing a single uptake versus multiple uptakes is minimal; therefore, the panel felt it was appropriate to represent both procedures as a single procedure code. Based on the 2010 data in which 78007 is the more common service, we considered thyroid imaging without multiple uptakes to be typical for the purposes of the survey. Ninety-five percent of the survey respondents stated that the vignette was typical.

A joint ACNM, SNM and ACR RVS panel (ACNM/SNM/ACR) reviewed and discussed the survey results. There were 129 responses to the survey request. The survey performance rate median of 70 studies per year among the 129 respondents is a reasonable rate given the higher volume of the 2010 codes which make up 78014 compared to those which make up 78012 and 78013, the other two surveyed thyroid procedure codes. The panel recommends pre-service package XXX, and adjusted both the pre and post service times from 6 minutes to our recommended value of 5 minutes. We believe the survey median 15 minutes intra-service time is excessive for a single uptake study; therefore, the panel elected to assign an intra-service time of 10 minutes, between the 25th and median to maintain relativity with 78013. The 25th percentile intra service time of 8 minutes would have created a rank order anomaly with the 10 minutes of intra-service time for 78013. While our RVW recommendation is higher for 78014 than 78013, the additional intensity is warranted, considering that 78014 includes the activities of 78012 and 78013.

The panel felt that the median and 25th percentile RVW appropriately capture the relativity between the procedures in the family; however, the RVW values for this family did not correlate well with RVW values of other nuclear medicine code families that have been RUC and CMS valued. The crosswalk current CPT codes 78006 (RVW-0.49) and 78007 (RVW-0.50) will now be reported with code (78014). The panel discussed at length compelling evidence arguments to support the survey median or 25th percentile results. The ACNM/SNM/ACR panel believed that the original Harvard value had likely undervalued this procedure. However, the reason for the current change in coding was to better describe the services and simplify the coding structure for these low volume procedures. These codes were surveyed in response to the RAW request, but we believe these procedures have not fundamentally changed over the years. As there was insufficient compelling evidence for higher values for 78014 or the family of thyroid codes, we are recommending to maintain the current RVWs of the highest volume crosswalked CPT code for valuation. We continue to urge the RUC to accept "Harvard valued" as a criterion for compelling evidence, which we believe would apply to CPT 78014 and which we believe our survey data supports.

We believe the reference service code chosen by the survey respondents, CPT 78227 (*Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed*) (RVW 0.90) has higher work intensity and complexity than 78014, and with 78227 having a longer intra-service time of 15 minutes and being ranked higher on the intensity factors for medical decision making, risk of significant complications and risk of malpractice.

We compared 78014 to a MPC code CPT 77300 (*Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician),* (RVW 0.62). While we believe these procedures are comparable in intensity and complexity, the panel agreed that 78014 should be valued slightly lower than both 77300 and CPT 78306 (*Bone and/or joint imaging; whole body)*, (RVW 0.86).
In summary, to maintain rank order and remain within budget neutrality we recommend a RVW of 0.50 for 78014 with a pre service time of 5minutes, intra service time of 10 minutes, and post service time of 5 minutes, for a total time of 20 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 78006, 78007

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 149073
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 78014 might be provided 149,073 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 97261 Percentage 65.24 %

Specialty Nuclear Medicine Frequency 18251 Percentage 12.24 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 49,691 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Codes 78006 and 78007 are currently used to report the procedure described by 78014. The 2010 Medicare frequency for code 78006 is 20,307 and the frequency for 78007 is 29,384. To calculate the frequency for code 78014, we summed the frequencies for the two codes to get 49,691.
Then, multiply the frequency for each code, 78006 and 78007, by the appropriate frequency (percent) for each specialty, Diagnostic Radiology or Nuclear Medicine, to estimate the number of times the specialty might provide the service described by 78014 to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 32420 Percentage 65.24 %

Specialty Nuclear Medicine Frequency 6084 Percentage 12.24 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 78007

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Thyroid Uptake/Imaging

TAB: 22

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	78226	Hepatobiliary system imaging, including gallbladder when present;	24	0.052			0.74			20	5					10			5
CURRENT	78000	Thyroid uptake; single determination		0.014			0.19			14						14			
CURRENT	78001	Thyroid uptake; multiple determinations		0.015			0.26			17						17			
CURRENT	78003	Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)		0.017			0.33			19						19			
SVY	78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or dis	118	0.063	0.15	0.60	0.85	1.00	51.80	20	5			0	5	10	15	40	5
REC	78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge		-0.007			0.19			15	5					5			5

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	78226	Hepatobiliary system imaging, including gallbladder when present;	25	0.052			0.74			20	5					10			5
CURRENT	78010	Thyroid imaging; only		0.023			0.39			17						17			
CURRENT	78011	Thyroid imaging; with vascular flow		0.023			0.45			20						20			
SVY	78013	Thyroid imaging (including vascular flow, when performed);	113	0.056	0.30	0.75	0.90	1.05	37.00	22	5			0	10	12	20	45	5
REC	78013	Thyroid imaging (including vascular flow, when performed);		0.015			0.37			20	5					10			5

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, inclu	24	0.044			0.90			26	6					15			5
CURRENT	78006	Thyroid imaging, with uptake; single determination		0.025			0.49			20						20			
CURRENT	78007	Thyroid imaging, with uptake; multiple determinations		0.021			0.50			24						24			
SVY	78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative	129	0.049	0.48	0.90	1.00	1.23	37.00	27	6			0	8	15	20	55	6
REC	78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measu		0.028			0.50			20	5					10			5

CPT Code: 78012, 78013, and 78014
Specialty Society('s) SNM, ACR, ACNM

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
78012 – Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed)
78013 – Thyroid imaging (including vascular flow, when performed);
78014 - Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed)

Global Period: XXX Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel was utilized to finalize the practice expense data for codes 78012, 78013, and 78014. Specialty societies that were involved include the Society of Nuclear Medicine, the American College of Radiology, and the American College of Nuclear Medicine.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Practice expense inputs for relevant nuclear medicine codes were used as a reference to provide practice expense inputs for codes 78012, 78013, and 78014.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy.
- QC Planar Equipment
- Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent including mandatory radiation education
- Prepare room, equipment, supplies (additional change collimator and set up protocol)
- Prepare and position patient/ monitor patient
- Obtain RP from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Administer RP oral 2 minutes IV 5 minutes procedure
- Acquire images/ uptake(s) and review for completeness and quality
- Complete diagnostic forms, lab & X-ray requisitions, image processing uptake calculation, development hard copy or complete calculation template, archive and obtain approval to discharge patient
- Clean room/equipment by physician staff
- Specific room clean up of RP injection/administration areas with mandatory defacement of labels for proper RP residual disposal
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				78000		78012		78010		78013		78007		78014	
3	**Meeting Date: April 2012 REVISED 4-28-2012** **Tab: 22** **Specialty: SNM, ACNM, ACR**	**CMS Code**	**Staff Type**	Thyroid uptake; single determination **PEAC March 2004**		Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed) **April 2012**		Thyroid imaging; only **PEAC Jan 2004**		Thyroid imaging (including vascular flow, when performed); **April 2012**		Thyroid imaging, with uptake; multiple determinations **PEAC Jan 2004**		Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed) **April 2012**	
4	**LOCATION**	**L049A**	**NMT**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**			**79.0**	**0.0**	**80.0**	**0.0**	**92.0**	**0.0**	**88.0**	**0.0**	**122.0**	**0.0**	**105.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**23.0**	**0.0**	**20.0**	**0.0**	**23.0**	**0.0**	**20.0**	**0.0**	**23.0**	**0.0**	**20.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**56.0**	**0.0**	**60.0**	**0.0**	**69.0**	**0.0**	**68.0**	**0.0**	**99.0**	**0.0**	**85.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	**L049A**	**NMT**	**6**		**3**		**6**		**3**		**6**		**3**	
13	QC Planar Equipment	**L049A**	**NMT**	**4**		**4**		**4**		**4**		**4**		**4**	
14	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.	**L049A**	**NMT**	**13**		**13**		**13**		**13**		**13**		**13**	
15	**End: When patient enters office/facility for surgery/procedure**														
16	**SERVICE PERIOD**														
17	**Start: When patient enters office/facility for surgery/procedure:**														
18	Greet patient, provide gowning, ensure appropriate medical records are available	**L049A**	**NMT**	**3**		**3**		**3**		**3**		**3**		**3**	
19	Provide pre-service education/obtain consent including mandatory radiation education	**L049A**	**NMT**	**3**		**3**		**3**		**3**		**3**		**3**	
20	Prepare room, equipment, supplies (additional change collimator and set up protocol)	**L049A**	**NMT**	**3**		**2**		**3**		**2**		**3**		**2**	
21	**Intra-service**														
22	Prepare and position patient/ monitor patient	**L049A**	**NMT**	**2**		**2**		**2**		**2**		**2**		**2**	
23	Obtain RP from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	**L049A**	**NMT**	**5**		**5**		**5**		**5**		**5**		**5**	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				78000		78012		78010		78013		78007		78014	
3	**Meeting Date: April 2012 REVISED 4-28-2012** **Tab: 22** **Specialty: SNM, ACNM, ACR**	**CMS Code**	**Staff Type**	Thyroid uptake; single determination **PEAC March 2004**		Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed) **April 2012**		Thyroid imaging; only **PEAC Jan 2004**		Thyroid imaging (including vascular flow, when performed); **April 2012**		Thyroid imaging, with uptake; multiple determinations **PEAC Jan 2004**		Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed) **April 2012**	
4	**LOCATION**	**L049A**	**NMT**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
24	Administer RP oral 2 minutes IV 5 minutes procedure	**L049A**	**NMT**	**2**		**2**		**5**		**5**		**2**		**2**	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
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5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
25	Acquire images/ uptake(s) and review for completeness and quality	**L049A**	**NMT**	**20**		**20**		**25**		**25**		**40**		**40**	
26	Complete diagnostic forms, lab & X-ray requisitions, image processing uptake calculation, development hard copy or complete calculation template, archive and obtain approval to discharge patient	**L049A**	**NMT**	**5**		**10**		**10**		**10**		**15**		**15**	
27	**Post-Service**														
28	Clean room/equipment by physician staff	**L049A**	**NMT**	**3**		**3**		**3**		**3**		**3**		**3**	
29	Specific room clean up of RP injection/administration areas with mandatory defacement of labels for proper RP residual disposal	**L049A**	**NMT**	**5**		**5**		**5**		**5**		**5**		**5**	
30	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	**L049A**	**NMT**	**5**		**5**		**5**		**5**		**5**		**5**	
31	**End: Patient leaves office**														
32	**POST-SERVICE Period**														
33	**Start: Patient leaves office/facility**														
43	**End: with last office visit before end of global period**														
44	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
45	pack, minimum multi-specialty visit	SA048	**pack**					**1**		**0**		**1**		**0**	
46	pillow case	SB037	**item**							**1**				**1**	
47	gloves, non-sterile	SB022	**pair**	**3**		**3**		**1**		**2**				**3**	
48	underpad 2ft x 3ft (Chux)	SB044	**item**					**1**		**1**		**1**		**1**	
49	angiocatheter 14g-24g	SC001	**item**					**1**		**1**		**1**		**1**	
50	heparin lock	SC012	**item**					**1**		**1**		**1**		**1**	
51	needle, 18-27g	SC029	**item**					**1**		**1**		**1**		**1**	
52	stop cock, 3-way	SC049	**item**					**1**		**1**		**1**		**1**	
53	syringe 10-12ml	SC051	**item**					**1**		**1**		**1**		**1**	
54	bandage, strip 0.75in x 3in (Bandaid)	SG021	**item**					**1**		**1**		**1**		**1**	
55	gauze, non-sterile 2in x 2in	SG050	**item**					**1**		**1**		**1**		**1**	
56	heparin lock flush soln	SH040	**item**					**1**		**1**		**1**		**1**	
57	swab-pad, alcohol	SJ053	**item**					**2**		**2**		**2**		**2**	
58	film, x-ray 8in x 10in	SK037	**item**					**2**		**2**		**2**		**2**	
59	x-ray envelope	SK091	**item**					**1**		**1**		**1**		**1**	

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5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
60	x-ray fixer solution	SK092	**oz**					**2**		**2**		**2**		**2**	
61	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	**item**	**2**		**2**		**5**		**5**		**5**		**5**	
62	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	**item**							**1**		**1**		**1**	
63	x-ray developer solution	SK089	**oz**							**2**		**2**		**2**	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
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5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
64	**EQUIPMENT**	**CODE**													
65	gamma counter, automatic	**ER033**		**21**		**28**		**24**		**28**		**27**		**28**	
66	thyroid uptake system	**ER063**		**28**		**40**		**0**		**0**		**0**		**65**	
67	computer workstation, nuclear pharmacy management (hardware and software)	**ED020**		**35**		**26**		**28**		**26**		**31**		**26**	
68	dose calibrator (Atomlab)	**ER027**		**25**		**28**		**28**		**28**		**31**		**28**	
69	chair, thyroid imaging	**EF010**		**28**		**40**		**0**		**0**		**0**		**65**	
70	dose calibration source vial set (Cs137, Co57, and Ba137)	**ER026**		**17**		**28**		**16**		**28**		**16**		**28**	
71	radiation survey meter	**ER054**		**17**		**18**		**17**		**18**		**17**		**18**	
72	radiation L-block tabletop shield	**ER053**		**21**		**28**		**24**		**28**		**27**		**28**	
73	computer workstation, nuclear medicine analysis-viewing	**ED019**		**0**		**0**		**33**		**10**		**58**		**15**	
74	film processor, wet	**ED025**		**0**		**0**		**3**		**3**		**3**		**3**	
75	Cobalt-57 Flood Source (47cm dia) (10 mCi)	**ER001**		**0**		**0**		**4**		**4**		**4**		**4**	
76	gamma camera system, single-dual head	**ER032**		**0**		**0**		**25**		**48**		**49**		**65**	
77	safe, storage, lead-lined	**ER058**		**0**		**28**		**24**		**28**		**27**		**28**	
78	x-ray view box, 4 panel	**ER067**		**0**		**0**		**10**		**0**		**11**		**0**	
79	bed, hospital, electric	**EF002**		**0**		**0**		**0**		**0**		**22**		**0**	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued-Utilization over 30,000

April 2012

Parathyroid Imaging

In April 2011, CPT Code 78007 *Thyroid imaging, with uptake; multiple determinations* was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology.

78070 *Parathyroid planar imaging (including subtraction, when performed);*
The RUC reviewed survey results from 102 radiologists and nuclear medicine physicians and recommends a work RVU of 0.80, the survey 25th percentile. The RUC noted that 78070 was editorially revised to clarify imaging by planar technique and has a current work RVU of 0.82. However, the RUC agreed that the 25th percentile work RVU of 0.80 should be assigned. The RUC compared code 78070 to CPT code 78226 *Hepatobiliary system imaging, including gallbladder when present* (work RVU=0.74) and noted that although these two procedures require the same physician time, 78070 is a dual-phase study which requires more physician work. The RUC also reviewed 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU=0.81) and determined that the physician times are similar and they are comparable tests. **The RUC recommends a work RVU of 0.80 for CPT Code 78070**.

78071 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)*
The RUC reviewed survey results from 94 radiologists and nuclear medicine physicians and determined that a work RVU of 1.20, the survey median, is appropriate. The RUC noted that currently this procedure is reported using CPT codes 78070 *Parathyroid imaging* (work RVU=0.82) and 78803 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)* (work RVU=1.09). The RUC compared 78071 to key reference service 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU=1.62) and determined that 78452 requires more physician time and should be valued higher than 78071. The RUC also reviewed 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (work RVU=1.19) and agreed that physician times and work are comparable. To further support a work RVU of 1.20, the RUC also reviewed 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU=1.27) and 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work

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RVU=1.34) and determined these procedures require similar physician time and intensity. **The RUC recommends a work RVU of 1.20 for CPT Code 78071.**

78072 ***Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization***
This service reflects new technology currently reported with unlisted codes. The RUC reviewed survey results from 86 radiologists and nuclear medicine physicians and determined that a work RVU of 1.60, the survey median, is appropriate. The RUC reviewed key reference service 78814 *Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)* (work RVU=2.20) and agreed that with 30 additional total minutes and higher intensity, the reference code should be valued higher. The RUC also reviewed 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU=1.35) and determined that this was a less intense procedure compared to the surveyed code. There was consensus among the RUC that, giving these comparators, a work RVU of 1.60 would maintain proper rank order among this family of services. **The RUC recommends a work RVU of 1.60 for CPT Code 78072.**

Work Neutrality:
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code (●New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
●78070	U1	Parathyroid planar imaging (including subtraction, when performed);	XXX	0.80

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● 78071	U2	with tomographic (SPECT)	XXX	1.20
● 78072	U3	with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	XXX	1.60

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78070 Tracking Number U1 Original Specialty Recommended RVU: **0.82**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: Parathyroid planar imaging (including subtraction, when performed);

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old woman with elevated calcium levels and elevated PTH, presents for evaluation of suspected hyperfunctioning parathyroid glands.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 8%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including available prior imaging studies and determines the appropriateness of the requested study; prescribes, oversees and directs the administered radiopharmaceutical(s) dose(s).

Description of Intra-Service Work: The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.
The complete study consists of a minimum of two separate sets of planar imaging data encompassing the lower neck and the mediastinum, and techniques to differentiate radiopharmaceutical accumulation in anomalous or abnormal parathyroid glands from in the thyroid gland. The typical method is injection of a single radiopharmaceutical (99mTc-sestamibi) that is accumulated by both endocrine glands, but washes out of the thyroid gland faster than from parathyroid hyperplastic and adenomatous tissue. Anterior and bilateral anterior oblique images of the neck and anterior mediastinal images are acquired 10 -30 minutes and again at 90 -240 minutes after injection. A dual radiopharmaceutical technique is less commonly done acquiring similar but pre-timed sequential images for 5 minutes each over a 30-minute period without moving the patient.
Whichever technique is used, thyroid and parathyroid imaging data are qualitatively compared to detect tissue uptake that is seen on the latter but is not present on the former, to reveal discordant parathyroid uptake and its relative location. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or reprocess data, when necessary.
The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The imaging data are compared to relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. Imaging data is normally reviewed with the referring physician when surgery is anticipated and may be discussed with the patient. The physician provides mandatory NRC regulatory review and oversight of the radiopharmaceutical throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; Kenneth McKusick, MD; Gary Dillehay, MD; Scott C. Bartley, MD				
Specialty(s):	Society of Nuclear Medicine, American College of Radiology, and American College of Nuclear Medicine				
CPT Code:	78070				
Sample Size:	2954	**Resp N:**	102	**Response:** 3.4 %	
Description of Sample:	The ACNM, SNM and ACR randomly selected 2,954 and sent an email with a survey request. There were 102 responses.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**25.00**	50.00	350.00
Survey RVW:	0.25	0.80	**0.90**	1.03	2.01
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	8.00	**10.00**	20.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	78070	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78226	XXX	0.74	**RUC Time**

CPT Descriptor Hepatobiliary system imaging, including gallbladder when present;

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,040,905

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
78306	XXX	0.86	**RUC Time**

CPT Descriptor Bone and/or joint imaging; whole body

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 21.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 78070**	**Key Reference CPT Code:** 78226	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**20.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.68	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.91
Urgency of medical decision making	2.00	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.59	2.68
Physical effort required	1.86	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.36	2.77
Outcome depends on the skill and judgment of physician	3.27	3.27
Estimated risk of malpractice suit with poor outcome	2.36	2.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.27	2.14
Intra-Service intensity/complexity	2.68	2.73
Post-Service intensity/complexity	2.14	2.24

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78007 *(Thyroid imaging, with uptake; multiple determinations)* was identified as a potentially mis-valued code through the Harvard-valued, volume greater than 30,000 utilization screen. The joint societies, ACNM, SNM, and ACR, presented an action plan to revise the thyroid family, CPT codes 78000 to 78010 in the Nuclear Medicine section

under the Endocrine System in CPT. CPT changes with survey results are presented in Tab 22. As part of this review of the entire endocrine system section, the joint societies determined that the parathyroid imaging procedures would benefit from revisions that would bring the coding structure current with bundling policies, guideline changes, and new technology. The new parathyroid family of codes editorially modifies one existing CPT code, creates one bundled code from two existing CPT codes, and creates a second new technology procedure code to report the varying procedures, and to conform to recently updated society procedure guidelines.

78070 Parathyroid planar imaging (including subtraction, when performed);
78070 is an existing code (RVW 0.82, 15 minutes total time), which was editorially revised to clarify imaging by planar technique. Our expert panel considered a two-phase early and late planar imaging study that includes subtraction by either visual or by computer processing to be typical for 78070. 94% percent of the survey respondents stated that the vignette was typical.

There were 102 responses to the survey request. The survey performance rate median of 25 studies per year among the 102 respondents is a reasonable rate given this is a relatively low volume procedure (27,900 in 2010). The panel agreed that the survey physician median times of 5 minutes pre-service, and 5 minutes post-service accurately reflect the time required to perform this service. Therefore, we selected pre-service XXX global package and adjusted the times to our recommended value of 5 minutes. We believe the survey median of 10 minutes of intra-service time for this dual-phase planar parathyroid study to be appropriate and comparable with other similar nuclear medicine studies.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 78070

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Nuclear Medicine How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 83700
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 78070 might be provided 83,700 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 55250 Percentage 66.00 %

Specialty Nuclear Medicine Frequency 14262 Percentage 17.03 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 27,900 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare frequency for code 78070 is 27,900. To estimate the number of times the specialty, Diagnostic Radiology or Nuclear Medicine, might provide the service described by 78070 to Medicare patients nationally in a one-year period, multiply 27,900 by the appropriate frequency (percent) for each specialty.

Specialty Diagnostic Radiology Frequency 18417 Percentage 66.01 %

Specialty Nuclear Medicine Frequency 4754 Percentage 17.03 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 78070

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78071 Tracking Number U2 Original Specialty Recommended RVU: **1.20**
Presented Recommended RVU: **1.20**
Global Period: XXX RUC Recommended RVU: **1.20**

CPT Descriptor: Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old man with chronic renal failure and clinical evidence for hyperparathyroidism. Ultrasound shows suspicious nodule posterior to the right lobe of the thyroid.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including available prior imaging studies and determines the appropriateness of the requested study; prescribes, oversees and directs the administered radiopharmaceutical(s) dose(s).

Description of Intra-Service Work: The physician directs the technologist in the timing of the SPECT study and to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.
The complete study consists of a minimum of two separate sets of planar imaging data encompassing the lower neck and the mediastinum, and techniques to differentiate radiopharmaceutical accumulation in anomalous or abnormal parathyroid glands from in the thyroid gland; plus a SPECT study of the same regions. The most commonly employed method is injection of a single radiopharmaceutical (99mTc-sestamibi) that is accumulated by both endocrine glands, but washes out of the thyroid gland faster than from parathyroid hyperplastic and adenomatous tissue. Anterior and bilateral anterior oblique planar images of the neck and anterior mediastinal images are acquired 10 -30 minutes and again at 90 - 240 minutes after injection. A SPECT study of the neck and mediastinum is acquired. A dual radiopharmaceutical technique is less commonly done acquiring similar but pre-timed sequential images for 5 minutes each over a 30-minute period without moving the patient, followed by a SPECT study of the neck and mediastinum.
Whichever technique is used (single or dual radiopharmaceutical), thyroid and parathyroid imaging data are qualitatively compared to detect tissue uptake that is seen on the latter but is not present on the former, to reveal discordant parathyroid uptake and its relative location for possible excision. The SPECT data are reconstructed in transaxial, sagittal and coronal planes to facilitate localization of abnormal parathyroid radiopharmaceutical accumulation.
The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data, when necessary.

The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The imaging data are compared to relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. Imaging data is normally reviewed with the referring physician and may be discussed with the patient. The physician provides mandatory NRC regulatory review and oversight of the radiopharmaceutical throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; Kenneth McKusick, MD; Gary Dillehay, MD; Scott C. Bartley, MD		
Specialty(s):	Society of Nuclear Medicine, American College of Radiology, and American College of Nuclear Medicine		
CPT Code:	78071		
Sample Size:	2954	**Resp N:** 94	**Response:** 3.1 %
Description of Sample:	ACNM, SNM and ACR randomly selected 2,954 members and sent an email with a survey request. There were 94 responses,		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	20.00	**30.00**	69.00	350.00
Survey RVW:	0.70	1.02	**1.20**	1.50	5.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**15.00**	25.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	78071	**Recommended Physician Work RVU: 1.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78452	XXX	1.62	**RUC Time**

CPT Descriptor Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78315	XXX	1.02	**RUC Time**	99,002

CPT Descriptor 1 Bone and/or joint imaging; 3 phase study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78494	XXX	1.19	**RUC Time**	5,328

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 15.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 78071**	**Key Reference CPT Code:** 78452	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	10.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**25.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.93	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	4.00
Urgency of medical decision making	2.80	4.07
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.79	3.79
Physical effort required	2.79	3.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.73	3.53
Outcome depends on the skill and judgment of physician	4.27	4.36
Estimated risk of malpractice suit with poor outcome	3.27	3.93

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.53	2.64
Intra-Service intensity/complexity	4.20	4.00
Post-Service intensity/complexity	2.93	3.07

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78007 *(Thyroid imaging, with uptake; multiple determinations)* was identified as a potentially mis-valued

code through the Harvard-valued, volume greater than 30,000 utilization screen. The joint societies, ACNM, SNM, and ACR, presented an action plan to revise the thyroid family, CPT codes 78000 to 78010 in the Nuclear Medicine section under the Endocrine System in CPT. CPT changes with survey results are presented in Tab 22. As part of this review of the entire endocrine system section, the joint societies determined that the parathyroid imaging procedures would benefit from revisions that would bring the coding structure current with bundling policies, guideline changes, and new technology. The new parathyroid family of codes editorially modifies one existing CPT code, creates one bundled code from two existing CPT codes, and creates a second new technology procedure code to report the varying procedures, and to conform to recently updated society procedure guidelines.

78071 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)
78071 is a new bundled procedure code reflecting the current billing of 78070 plus 78803 *(Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT))*. Even though 78803 has other utilization outside of parathyroid imaging and the code combination for this indication did not appear on the CMS 75 percent list, we believe there is a significant percentage of these two codes being billed together. We also have received numerous member coding questions regarding billing for parathyroid imaging with SPECT, which prompted the societies to bring this family forward.

For the purpose of this RUC survey, the 2010 predominant "typical" procedure is a two-phase early and late planar imaging including subtraction by one of two methods, visually or by computer processing, plus a SPECT study. Eighty percent of the survey respondents stated that the vignette was typical.

A joint ACNM/SNM/ACR panel reviewed the survey results. There were 94 responses to the survey request. The survey performance rate median of 30 studies per year among the 94 respondents is a reasonable rate given the volume for these procedures. The panel agreed that the survey physician median times of 5 minutes pre-service and 5 minutes post-service accurately reflect the time required to perform this service. Therefore, we selected pre-service XXX global package and adjusted the times to our recommended value of 5 minutes. We believe the survey median of 15 minutes intra-service time is appropriate and comparable with other similar nuclear medicine studies.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 78070, 78803

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Nuclear medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 93054
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 7807X1 might be provided 93,054 times in a one-year period.

Specialty Diagnostic Radiology Frequency 61462 Percentage 66.04 %

Specialty Nuclear Medicine Frequency 16592 Percentage 17.83 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 31,018 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Codes 78070 and 78803 are currently used to report the procedure described by 78071. The 2010 Medicare frequency for code 78070 is 27,900 and 14,173 for code 78803. To calculate the frequency for code 78071, we took the frequency for code 78070 plus part of the frequency for code 78803 (NM accounts for 22% of 78803, which is equal to 3,118).
Then, multiply the frequency for each code, 78070 and 78803, by the appropriate frequency (percent) for each specialty, Diagnostic Radiology or Nuclear Medicine, to estimate the number of times the specialty might provide the service described by 78071 to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 20487 Percentage 66.04 %

Specialty Nuclear Medicine Frequency 5531 Percentage 17.83 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 78803

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78072 Tracking Number U3 Original Specialty Recommended RVU: **1.60**
Presented Recommended RVU: **1.60**
Global Period: XXX RUC Recommended RVU: **1.60**

CPT Descriptor: Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old woman with past history of neck exploration and resection of hyperplastic parathyroid glands, now presents with evidence of recurrent hyperparathyroidism, thyroid ultrasound is negative.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including available prior imaging studies and determines the appropriateness of the requested study; prescribes, oversees and directs the administered radiopharmaceutical(s) dose(s).

Description of Intra-Service Work: The physician directs the technologist in the timing of the SPECT/CT study and to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.
The complete study consists of a minimum of two separate sets of planar imaging data encompassing the lower neck and the mediastinum, and techniques to differentiate radiopharmaceutical accumulation in anomalous or abnormal parathyroid glands from in the thyroid gland; plus a SPECT/CT study of the same regions. The typical protocol is injection of a single radiopharmaceutical (99mTc-sestamibi) that is accumulated by both endocrine glands, but washes out of the thyroid gland faster than from parathyroid hyperplastic and adenomatous tissue. Anterior and bilateral anterior oblique planar images of the neck and anterior mediastinal images are acquired 10-30 minutes and again at 90-240 minutes after injection. A limited CT study of the neck and mediastinum is acquired, and without moving the patient a SPECT study of the same regions is acquired. A dual radiopharmaceutical technique is less commonly done acquiring similar but pre-timed sequential images for 5 minutes each over a 30-minute period without moving the patient, followed by a limited CT study of the neck and mediastinum and again without moving the patient acquisition of a SPECT study of the same regions.
Whichever technique is used (single or dual radiopharmaceutical), thyroid and parathyroid imaging data are qualitatively compared to detect tissue uptake that is seen on the latter but is not present on the former, to reveal discordant parathyroid uptake and its relative location for possible excision. The SPECT and CT data are reconstructed in transaxial, sagittal and coronal planes to facilitate localization of abnormal parathyroid radiopharmaceutical accumulation. CT data is also used to

generate attenuation corrected images in all three planes. Additional fused images from the SPECT and CT images are constructed to correlate the anatomic position of radiopharmaceutical accumulation with the current patient anatomy.
The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data, when necessary.
The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The imaging data are compared to relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. Imaging data is normally reviewed with the referring physician and may be and may be discussed with the patient. The physician provides mandatory NRC regulatory review and oversight of the radiopharmaceutical throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; Kenneth McKusick, MD; Gary Dillehay, MD; Scott C. Bartley, MD		
Specialty(s):	Society of Nuclear Medicine, American College of Radiology, and American College of Nuclear Medicine		
CPT Code:	78072		
Sample Size:	2954	**Resp N:** 86	**Response:** 2.9 %
Description of Sample:	ACNM, SNM and ACR randomly selected 2,954 and emailed a survey request. There were 86 responses.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	**30.00**	50.00	350.00
Survey RVW:	0.80	1.29	**1.60**	2.00	4.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	13.00	**20.00**	30.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	78072	**Recommended Physician Work RVU: 1.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78814	XXX	2.20	**RUC Time**

CPT Descriptor Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	599,170

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	127,977

CPT Descriptor 2 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 32.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 78072**	**Key Reference CPT Code:** 78814	**Source of Time RUC Time**
Median Pre-Service Time	5.00	15.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**30.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.43
Urgency of medical decision making	2.79	3.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.22	4.43
Physical effort required	2.75	2.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.07	3.50
Outcome depends on the skill and judgment of physician	4.11	4.37
Estimated risk of malpractice suit with poor outcome	3.00	3.61

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.14	3.43
Intra-Service intensity/complexity	4.07	4.25
Post-Service intensity/complexity	3.04	3.36

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78007 *(Thyroid imaging, with uptake; multiple determinations)* was identified as a potentially mis-valued code through the Harvard-valued, volume greater than 30,000 utilization screen. The joint societies, ACNM, SNM, and

ACR, presented an action plan to revise the thyroid family, CPT codes 78000 to 78010 in the Nuclear Medicine section under the Endocrine System in CPT. CPT changes with survey results are presented in Tab 22. As part of this review of the entire endocrine system section, the joint societies determined that the parathyroid imaging procedures would benefit from revisions that would bring the coding structure current with bundling policies, guideline changes, and new technology. The new parathyroid family of codes editorially modifies one existing CPT code, creates one bundled code from two existing CPT codes, and creates a second new technology procedure code to report the varying procedures, and to conform to recently updated society procedure guidelines.

78072 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

78072 is a new procedure, analogous to the PET/CT procedure codes. The CT component of this imaging exam is not a fully diagnostic CT, but rather a low-radiation dose, low-resolution CT used for the purposes of attenuation correction and anatomic localization. This procedure is more sensitive for parathyroid localization than the planar and/or SPECT imaging procedures above. Seventy-six percent of the survey respondents stated that the vignette describing a post-surgical patient was typical.

A joint ACNM, SNM, and ACR RVS expert panel reviewed and discussed the survey results. There were 86 responses to the survey request. The survey performance rate median of 30 studies per year among the 86 respondents is a reasonable rate given the low volume for this new procedure code. The panel agreed that the survey physician median times of 5 minutes pre-service, and 5 minutes post-service accurately reflect the time required to perform this service. The panel recommends pre-service XXX global package and adjusted the time to our recommended value of 5 minutes. We believe the survey median of 20 minutes intra-service time is appropriate and relative to the other codes in this family and to other nuclear medicine procedure codes that have been RUC reviewed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 78999, 78099

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Sometimes

Specialty Nuclear Medicine How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 491
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 78072 might be provided 491 times in a one-year period.

Specialty Diagnostic Radiology Frequency 27 Percentage 5.49 %

Specialty Nuclear Medicine Frequency 10 Percentage 2.03 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 164
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Unlisted procoedure codes 78999 and 78099 are currently used to report the procedure described by 78072. We based our estimate on only 50% of the Medicare frequency, 160 for 78999 and 4 for 78099, for a total of 164.
To estimate the number of times the specialty, Diagnostic Radiology or Nuclear Medicine, might provide the service described by 78072 to Medicare patients nationally in a one-year period, multiply the frequency for each code, 78999 and 78099, by the appropriate frequency (percent) for each specialty.

Specialty Diagnostic Radiology Frequency 9 Percentage 5.48 %

Specialty Nuclear Medicine Frequency 3 Percentage 1.82 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 78452

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Parathyroid Imaging

TAB: 23

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	78226	Hepatobiliary system imaging, including gallbladder when present;	22	0.052			0.74			20	5					10			5
CURRENT	78070	Parathyroid imaging		0.055			0.82			15						15			
SVY	78070	Parathyroid planar imaging (including subtraction, when performed);	102	0.068	0.25	0.80	0.90	1.03	2.01	20	5			0	8	10	20	30	5
REC	78070	Parathyroid planar imaging (including subtraction, when performed);		0.058			0.80			20	5					10			5

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or	15	0.059			1.62			40	10					20			10
CURRENT	78070	Parathyroid imaging		0.055			0.82			15						15			
CURRENT	78803	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SP		0.025			1.09			43						43			
SVY	78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	94	0.065	0.70	1.02	1.20	1.50	5.00	25	5			0	10	15	25	45	5
REC	78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)		0.065			1.20			25	5					15			5

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for atter	28	0.051			2.20			60	15					30			15
CURRENT	78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine		#DIV/0!						0									
CURRENT	78099	Unlisted endocrine procedure, diagnostic nuclear medicine		#DIV/0!						0									
SVY	78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and	86	0.069	0.80	1.29	1.60	2.00	4.00	30	5			0	13	20	30	45	5
REC	78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concu		0.069			1.60			30	5					20			5

CPT Code: 78070, 78071, and 78072
Specialty Society('s) SNM, ACR, ACNM

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
78070 – Parathyroid planar imaging (including subtraction, when performed);
78071 – Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)
78072 - Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

Global Period: XXX Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel was utilized to finalize the practice expense data for codes 78070, 78071, and 78072. Specialty societies that were involved include the Society of Nuclear Medicine, the American College of Radiology, and the American College of Nuclear Medicine.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

The existing code 78003 is being replaced, and 78070 has been editorially revised through the creation of new parathyroid imaging codes, 78070, 78071, and 78072.The practice expense inputs for the existing codes are similar to the practice expense inputs for the new codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy.
- QC Planar Equipment
- QC SPECT Equipment
- Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available

- Provide pre-service education/obtain consent including mandatory radiation education
- Prepare room, equipment, supplies (additional change collimator and set up protocol)
- Prepare and position patient/ monitor patient
- Obtain RP from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Administer RP oral 2 minutes IV 5 minutes procedure
- Acquire images/ uptake(s) and review for completeness and quality
- Complete diagnostic forms, lab & X-ray requisitions, image processing uptake calculation, development hard copy or complete calculation template, archive and obtain approval to discharge patient
- Clean room/equipment by physician staff
- Specific room clean-up of RP injection/administration areas with mandatory defacement of labels for proper RP residual disposal
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE				REFERENCE CODE					
2				78070		78070		78803		78071		78072	
3	**Meeting Date: April 2012 REVISED 4-28-2012** **Tab: 23** **Specialty: SNM, ACNM, ACR**	**CMS Code**	**Staff Type**	Parathyroid imaging PEAC Aug 2001		Parathyroid planar imaging (including subtraction, when performed); April 2012		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT) PEAC Jan 2004		Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) April 2012		Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization April 2012	
4	**LOCATION**	**L049A**	**NMT**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**			**133.0**	**0.0**	**113.0**	**0.0**	**137.0**	**0.0**	**126.0**	**0.0**	**136.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**23.0**	**0.0**	**20.0**	**0.0**	**28.0**	**0.0**	**23.0**	**0.0**	**23.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**110.0**	**0.0**	**93.0**	**0.0**	**109.0**	**0.0**	**103.0**	**0.0**	**113.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	**L049A**	NMT	**6**		**3**		**8**		**3**		**3**	
13	QC Planar Equipment	**L049A**	NMT	**4**		**4**							
14	QC SPECT Equipment	**L049A**	NMT					**7**		**7**		**7**	
15	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.	**L049A**	NMT	**13**		**13**		**13**		**13**		**13**	
16	**End: When patient enters office/facility for surgery/procedure**												
17	**SERVICE PERIOD**												
18	**Start: When patient enters office/facility for surgery/procedure:**												
19	Greet patient, provide gowning, ensure appropriate medical records are available	**L049A**	NMT	**3**		**3**		**3**		**3**		**3**	
20	Provide pre-service education/obtain consent including mandatory radiation education	**L049A**	NMT	**3**		**3**		**3**		**3**		**3**	
21	Prepare room, equipment, supplies (additional change collimator and set up protocol)	**L049A**	NMT	**3**		**2**		**3**		**2**		**2**	
22	**Intra-service**												
23	Prepare and position patient/ monitor patient	**L049A**	NMT	**2**		**2**		**2**		**2**		**2**	
24	Obtain RP from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	**L049A**	NMT	**5**		**5**		**5**		**5**		**5**	
25	Administer RP oral 2 minutes IV 5 minutes procedure	**L049A**	NMT	**5**		**5**		**5**		**5**		**5**	
26	Acquire images/ uptake(s) and review for completeness and quality	**L049A**	NMT	**66**		**55**		**65**		**65**		**75**	
27	Complete diagnostic forms, lab & X-ray requisitions, image processing uptake calculation, development hard copy or complete calculation template, archive and obtain approval to discharge patient	**L049A**	NMT	**10**		**5**		**10**		**5**		**5**	
28	**Post-Service**												
29	Clean room/equipment by physician staff	**L049A**	NMT	**3**		**3**		**3**		**3**		**3**	
30	Specific room clean up of RP injection/administration areas with mandatory defacement of labels for proper RP residual disposal	**L049A**	NMT	**5**		**5**		**5**		**5**		**5**	
31	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	**L049A**	NMT	**5**		**5**		**5**		**5**		**5**	
32	**End: Patient leaves office**												
33	**POST-SERVICE Period**												
34	**Start: Patient leaves office/facility**												
44	**End: with last office visit before end of global period**												

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE				REFERENCE CODE					
2				78070		78070		78803		78071		78072	
3	**Meeting Date: April 2012 REVISED 4-28-2012** **Tab: 23** **Specialty: SNM, ACNM, ACR**	**CMS Code**	**Staff Type**	Parathyroid imaging PEAC Aug 2001		Parathyroid planar imaging (including subtraction, when performed); April 2012		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT) PEAC Jan 2004		Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) April 2012		Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization April 2012	
4	**LOCATION**	**L049A**	**NMT**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
45	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
46	pack, minimum multi-specialty visit	SA048	pack	**2**		**0**		**0**		**0**		**0**	
47	pillow case	SB037	item			**2**				**2**		**2**	
48	drape, non-sterile, sheet 40in x 60in	SB006	item	**2**		**0**		**2**		**0**		**0**	
49	gloves, non-sterile	SB022	pair	**2**		**2**		**1**		**2**		**2**	
50	gown, patient	SB026	item	**0**		**0**		**1**		**0**		**0**	
51	underpad 2ft x 3ft (Chux)	SB044	item	**2**		**2**		**1**		**2**		**2**	
52	angiocatheter 14g-24g	SC001	item	**1**		**1**		**1**		**1**		**1**	
53	heparin lock	SC012	item	**1**		**1**		**0**		**1**		**1**	
54	iv infusion set	SC018	item	**0**		**1**		**2**		**1**		**1**	
55	iv tubing (extension)	SC019	foot	**0**		**1**		**1**		**1**		**1**	
56	needle, 18-27g	SC029	item	**2**		**2**		**3**		**2**		**2**	
57	needle, 19-25g, butterfly	SC030	item	**0**		**1**		**1**		**1**		**1**	
58	stop cock, 3-way	SC049	item	**1**		**1**		**1**		**1**		**1**	
59	syringe 10-12ml	SC051	item	**2**		**2**		**0**		**2**		**2**	
60	syringe 20ml	SC053	item	**0**		**1**		**1**		**1**		**1**	
61	syringe 5-6ml	SC057	item	**0**		**1**		**1**		**1**		**1**	
62	syringe-needle 3ml 22-26g	SC064	item	**0**		**1**		**1**		**1**		**1**	
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**		**1**		**1**		**1**		**1**	
64	bandage, tubular, x-large (Surgilast)	SG022	yd	**0**		**0**		**2**		**0**		**0**	
65	gauze, non-sterile 2in x 2in	SG050	item	**2**		**2**		**0**		**2**		**2**	
66	tape, surgical paper 1in (Micropore)	SG079	inch	**0**		**2**		**24**		**2**		**2**	
67	heparin lock flush soln	SH040	item	**1**		**0**		**0**		**0**		**0**	
68	electrode conductive gel	SJ020	ml	**0**		**0**		**5**		**0**		**0**	
69	swab-pad, alcohol	SJ053	item	**4**		**1**		**2**		**1**		**1**	
70	computer media, floppy disk 1.44mb	SK014	item	**0**		**0**		**1**		**0**		**0**	
71	film, x-ray 8in x 10in	SK037	item	**4**		**2**		**2**		**2**		**2**	
72	x-ray envelope	SK091	item	**1**		**1**		**0**		**1**		**1**	
73	x-ray fixer solution	SK092	oz	**4**		**2**		**0**		**2**		**2**	
74	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	**10**		**10**		**0**		**10**		**10**	
75	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	item	**2**		**2**		**0**		**2**		**2**	
76	x-ray developer solution	SK089	oz	**0**		**2**		**0**		**2**		**2**	
77	**EQUIPMENT**	**CODE**											
78	gamma counter, automatic	**ER033**		**21**		**19**		**21**		**22**		**22**	
79	computer workstation, nuclear pharmacy management (hardware and software)	**ED020**		**25**		**26**		**24**		**26**		**26**	
80	dose calibrator (Atomlab)	**ER027**		**25**		**28**		**25**		**28**		**28**	
81	dose calibration source vial set (Cs137, Co57, and Ba137)	**ER026**		**16**		**28**		**16**		**28**		**28**	
82	radiation survey meter	**ER054**		**17**		**18**		**16**		**18**		**18**	
83	radiation L-block tabletop shield	**ER053**		**21**		**28**		**21**		**28**		**28**	
84	computer workstation, nuclear medicine analysis-viewing	**ED019**		**0**		**5**		**72**		**5**		**5**	
85	film processor, wet	**ED025**		**0**		**2**		**5**		**5**		**5**	
86	Cobalt-57 Flood Source (47cm dia) (10 mCi)	**ER001**		**0**		**4**		**4**		**7**		**7**	
87	gamma camera system, single-dual head	**ER032**		**0**		**73**		**69**		**86**		**0**	
88	gamma camera system, single-dual head SPECT/CT	**NEW**		**0**		**0**		**0**		**0**		**96**	
89	safe, storage, lead-lined	**ER058**		**21**		**28**		**21**		**28**		**28**	
90	x-ray view box, 4 panel	**ER067**		**0**				**0**		**0**		**0**	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Molecular Pathology-Adenomatous Polyposis Coli

The College of American Pathologists explained to the RUC that these three Molecular Pathology codes, 81201, 81202 and 81203, are among the last and lowest volume Tier 1 molecular pathology codes developed by the CPT Editorial Panel. Previous attempts to survey low volume Molecular Pathology services have resulted in surveys with inadequate responses and it is suspected that these codes, performed by ultra-specialized molecular pathologists, would yield much less than adequate survey responses. At the September 2011 RUC meeting, the RUC agreed to crosswalk other low volume Tier 1 Molecular Pathology codes to Tier 2 molecular pathology codes. In February 2012 the RUC approved the Research Subcommittee and specialty request to use direct crosswalks to obtain credible values and time for these services.

The RUC reviewed CPT code 81201 *APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence* and agreed to directly crosswalk this service to the Molecular Pathology Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)* (work RVU= 1.40). This reference service is an accurate comparator for 81201 because Level 7 is the Tier 2 level to which 81201 would have been assigned had it been placed on Tier 2 based on the physician work and practice expense involved in sequencing the 15 coding exons of the APC gene. . **The RUC recommends a work RVU of 1.40 and intra-service time of 60 minutes for CPT code 81201.**

The RUC reviewed CPT code 81202 *APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants* and agreed to directly crosswalk this service to the Molecular Pathology Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (work RVU= 0.52). The RUC agreed that 81202 involves the physician work of DNA sequence analysis of a single exon, and not a full gene sequence analysis, compared to 81201. Therefore, 81202 should be valued the same as reference code 81403, which also describes the physician work of analyzing a single exon by DNA sequence analysis. **The RUC recommends a work RUV of 0.52 and intra-service time of 28 minutes for CPT code 81202.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC reviewed CPT code 81203 *APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants* and agreed to directly crosswalk this service to the Molecular Pathology Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* (work RVU= 0.80).Level 6 is the Tier 2 level to which 81203 would have been assigned had it been placed on Tier 2 based on the physician work and practice expense involved in duplication/deletion analysis of the 15 coding exons of the APC gene, and the RUC agreed that 81203 represents the physician work involved with duplication deletion analysis of 11 – 25 exons. The RUC noted that this service has physician work that is more complex than 81202 but less complex than 81201 and is correctly valued in between the two services. **The RUC recommends a work RVU of 0.80 and intra-service time of 30 minutes for CPT code 81203.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs as approved by the Practice Expense Subcommittee.

New Technology: These services will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81201	V1	*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	XXX	1.40
●81202	V2	known familial variants	XXX	0.52
●81203	V3	duplication/deletion variants	XXX	0.80

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

February 22, 2012

Barbara Lewis, DO
Chair
Research Subcommittee
RVS Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

RE: Additional Tier 1 Molecular Pathology CPT Codes

Dear Doctor Lewis;

The College of American Pathologists (CAP) will be presenting physician work and practice expense for three new category I molecular pathology services at the RUC's April 2012 meeting in Chicago. These three new services are among the last and lowest volume of the Tier 1 codes developed by the AMA CPT Molecular Pathology Coding Workgroup (MPCW). Earlier, in a separate letter to the RUC dated February 17, 2012, CAP recommended that these new codes be surveyed for their physician work involving physician interpretation.

After further consideration and reflection upon our previous survey efforts last year when CAP performed a survey of 68 new molecular pathology services, CAP's RBRVS workgroup believes that a full survey of these three codes which are performed by ultra-specialized molecular pathologists would yield much less than the typical minimum number of 30 survey respondents that the RUC typically desires.

At the September 2011 RUC meeting, CAP cross walked the values for low volume Tier 1 Molecular Pathology codes for which we did not receive adequate survey data to the Tier 2 Molecular Pathology level codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. As the remaining Tier 1 codes under consideration represent even lower volume services, we believe that cross walking the new codes to Tier 2 level codes represents the best option to maintain relativity and rank order in this new code family. If surveyed, we would anticipate a very low physician work survey response rate for these three services.

CAP requests that the RUC's Research Subcommittee accept the following relative value cross walks for the three new molecular pathology services to value the professional component for these services. The practice expense subcommittee will determine the practice expense recommendations for these codes.

New molecular pathology services with direct crosswalk codes listed below:

The following codes represent gene-specific and genomic procedures:

- 81201 *APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence **(Cross walk to 81406, see below)**
- 81202 known familial variants **(Cross walk to 81403, see below)**
- 81203 duplication/deletion variants **(Cross walk to 81405, see below)**

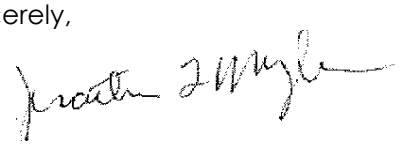
81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) (RUC Recommended Work RVU = 1.40, Intra-service Work Time = 60 minutes, IWPUT = 0.023)

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) (RUC Recommended Work RVU = 0.52, Intra-service Work Time = 28 minutes, IWPUT = 0.019)

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) (RUC Recommended Work RVU = 0.80, Intra-service Work Time = 30 minutes, IWPUT = 0.027)

If you have any questions or concerns, please contact, Todd Klemp, Assistant Director of Economic and Regulatory Affairs at (202) 354-7403 or tklemp@cap.org

Sincerely,



Jonathan L. Myles, MD, FCAP
RUC Advisor
College of American Pathologists

cc: Edith Hambrick, MD, JD, CMS
Pam Johnson, CAP Staff
Rosa Karbowiak, AMA
Todd Klemp, CAP Staff
Sherry Smith, AMA
Ayanna Wooding, CAP Staff

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81201 Tracking Number V1 Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.40**
Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male patient presents to his physician with episodic hematochezia. The patient undergoes colonoscopy. A very large number of adenomatous polyps and a left sided mass consistent with adenocarcinoma of the colon are identified. The patient's family history is positive for colon cancer in several relatives. Familial adenomatous polyposis (FAP) is suspected, and an anticoagulated peripheral blood sample is submitted for APC gene sequencing.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 15 individual PCR amplification reactions whose products encompass the entire coding sequence, intron-exon boundaries, and portions of the 5'and 3'-untranslated regions of the APC gene. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist or other qualified healthcare professional evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist or other qualified healthcare professional compares this evaluation with possible variants suggested by computer software to ensure that all abnormalities are identified. The pathologist or other healthcare professional composes a report which specifies the patient's mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jonathan Myles, MD, FCAP, Aaron Bossler, MD, PhD, and Roger Klein, MD, JD		
Specialty(s):	College of American Pathologists		
CPT Code:	81201		
Sample Size:	0	**Resp N:** 0	**Response:** 0.0 %
Description of Sample:	Crosswalk		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:					

Immediate Post Service-Time:	_____	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81201	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88323	XXX	1.83	**RUC Time**

CPT Descriptor Consultation and report on referred material requiring preparation of slides

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	12,454

CPT Descriptor 1 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	599,170

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code	Global	Work RVU	Time Source
49423	000	1.46	**RUC Time**

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81201**	**Key Reference CPT Code:** 88323	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	56.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**56.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The College of American Pathologists (CAP) recommends a cross walk of the physician work and practice expense for this service. These three new services are among the last and lowest volume of the Tier 1 codes developed by the AMA

CPT Molecular Pathology Coding Workgroup (MPCW). The RUC's Research Subcommittee agreed to this crosswalk methodology in February 2012.

CAP considered surveying for these services, however after further consideration and reflection upon our previous survey efforts last year when CAP performed a survey of 68 new molecular pathology services, CAP's RBRVS workgroup believes that a full survey of these three codes which are performed by ultra-specialized molecular pathologists would yield far fewer than the minimum number of 30 survey respondents that the RUC typically desires.

At the September 2011 RUC meeting, CAP cross walked the values for low volume Tier 1 Molecular Pathology codes for which we did not receive adequate survey data to the Tier 2 Molecular Pathology level codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. As the remaining Tier 1 codes under consideration represent even lower volume services, we believe that cross walking the new codes to Tier 2 level codes represents the best option to maintain relativity and rank order in this new code family.

CAP recommends the following relative value cross walks for the three new molecular pathology services to value the professional component for these services.

New molecular pathology services with direct crosswalk codes listed below:

The following codes represent gene-specific and genomic procedures:

- 81201 *APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence **(Cross walk to 81406, see below)**

- 81202 known familial variants **(Cross walk to 81403, see below)**

- 81203 duplication/deletion variants **(Cross walk to 81405, see below)**

81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) (RUC Recommended Work RVU = 1.40, Intra-service Work Time = 60 minutes, IWPUT = 0.023)

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) (RUC Recommended Work RVU = 0.52, Intra-service Work Time = 28 minutes, IWPUT = 0.019)

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) (RUC Recommended Work RVU = 0.80, Intra-service Work Time = 30 minutes, IWPUT = 0.027)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 83912

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 450
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Division of 83912

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81202 Tracking Number V2 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-year-old asymptomatic boy whose 40-year-old father was recently diagnosed with colon cancer and familial adenomatous polyposis (FAP) presents to his physician for genetic testing. The father has a disease-associated mutation in the APC gene. An anti-coagulated peripheral blood sample from the asymptomatic boy is submitted for testing for this known familial mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the respective APC exon that contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist or other qualified healthcare professional evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist or other qualified healthcare professional composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jonathan Myles, MD, FCAP, Aaron Bossler, MD, PhD, and Roger Klein, MD, JD		
Specialty(s):	College of American Pathologists		
CPT Code:	81202		
Sample Size:	0	**Resp N:** 0	**Response:** 0.0 %
Description of Sample:	Crosswalk		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:					

Immediate Post Service-Time:	_____	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81202	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,122,304

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
99407	XXX	0.50	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81202**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The College of American Pathologists (CAP) recommends a cross walk of the physician work and practice expense for this service. These three new services are among the last and lowest volume of the Tier 1 codes developed by the AMA CPT Molecular Pathology Coding Workgroup (MPCW). The RUC's Research Subcommittee agreed to this crosswalk methodology in February 2012.

CAP considered surveying for these services, however after further consideration and reflection upon our previous survey efforts last year when CAP performed a survey of 68 new molecular pathology services, CAP's RBRVS workgroup believes that a full survey of these three codes which are performed by ultra-specialized molecular pathologists would yield far fewer than the minimum number of 30 survey respondents that the RUC typically desires.

At the September 2011 RUC meeting, CAP cross walked the values for low volume Tier 1 Molecular Pathology codes for which we did not receive adequate survey data to the Tier 2 Molecular Pathology level codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. As the remaining Tier 1 codes under consideration represent even lower volume services, we believe that cross walking the new codes to Tier 2 level codes represents the best option to maintain relativity and rank order in this new code family

CAP recommends the following relative value cross walks for the three new molecular pathology services to value the professional component for these services.

New molecular pathology services with direct crosswalk codes listed below:

The following codes represent gene-specific and genomic procedures:

- 81201 *APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence **(Cross walk to 81406, see below)**
- 81202 known familial variants **(Cross walk to 81403, see below)**
- 81203 duplication/deletion variants **(Cross walk to 81405, see below)**

81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) (RUC Recommended Work RVU = 1.40, Intra-service Work Time = 60 minutes, IWPUT = 0.023)

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) (RUC Recommended Work RVU = 0.52, Intra-service Work Time = 28 minutes, IWPUT = 0.019)

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) (RUC Recommended Work RVU = 0.80, Intra-service Work Time = 30 minutes, IWPUT = 0.027)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 90 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. division of 83912

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81203 Tracking Number V3 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male patient presents with episodic hematochezia. The patient undergoes colonoscopy. A very large number of adenomatous polyps and a left sided mass consistent with adenocarcinoma of the colon are identified. Germline sequencing for the presence of an APC mutation does not reveal a mutation. Duplication/deletion analysis is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA), which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 15 exons of the APC gene to assess dosage of each exon. The pathologist or other qualified healthcare professional examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the APC gene. The pathologist or other qualified health care professional composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jonathan Myles, MD, FCAP, Aaron Bossler, MD, PhD, and Roger Klein, MD, JD		
Specialty(s):	College of American Pathologists		
CPT Code:	81203		
Sample Size:	0	**Resp N:** 0	**Response:** 0.0 %
Description of Sample:	Crosswalk Methodology		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:					

Immediate Post Service-Time:	_____	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81203	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88112	XXX	1.18	**RUC Time**

CPT Descriptor Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11100	000	0.81	**RUC Time**	2,702,007

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	XXX	0.75	**RUC Time**	152,826

CPT Descriptor 2 Injection(s); single tendon origin/insertion

Other Reference CPT Code	Global	Work RVU	Time Source
96406	000	0.80	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, more than 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81203**	**Key Reference CPT Code:** 88112	**Source of Time RUC Time**
Median Pre-Service Time	0.00	8.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**43.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The College of American Pathologists (CAP) recommends a cross walk of the physician work and practice expense for this service. These three new services are among the last and lowest volume of the Tier 1 codes developed by the AMA

CPT Molecular Pathology Coding Workgroup (MPCW). The RUC's Research Subcommittee agreed to this crosswalk methodology in February 2012.

CAP considered surveying for these services, however after further consideration and reflection upon our previous survey efforts last year when CAP performed a survey of 68 new molecular pathology services, CAP's RBRVS workgroup believes that a full survey of these three codes which are performed by ultra-specialized molecular pathologists would yield far fewer than the minimum number of 30 survey respondents that the RUC typically desires.

At the September 2011 RUC meeting, CAP cross walked the values for low volume Tier 1 Molecular Pathology codes for which we did not receive adequate survey data to the Tier 2 Molecular Pathology level codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. As the remaining Tier 1 codes under consideration represent even lower volume services, we believe that cross walking the new codes to Tier 2 level codes represents the best option to maintain relativity and rank order in this new code family CAP recommends the following relative value cross walks for the three new molecular pathology services to value the professional component for these services.

New molecular pathology services with direct crosswalk codes listed below:

The following codes represent gene-specific and genomic procedures:

- 81201 *APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence **(Cross walk to 81406, see below)**
- 81202 known familial variants **(Cross walk to 81403, see below)**
- 81203 duplication/deletion variants **(Cross walk to 81405, see below)**

81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) (RUC Recommended Work RVU = 1.40, Intra-service Work Time = 60 minutes, IWPUT = 0.023)

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) (RUC Recommended Work RVU = 0.52, Intra-service Work Time = 28 minutes, IWPUT = 0.019)

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) (RUC Recommended Work RVU = 0.80, Intra-service Work Time = 30 minutes, IWPUT = 0.027)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 450
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. division of 83912

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912

ISSUE: Molecular Pathology - Adenomatous Polyposis Coli

TAB: 24

New Services

Source	CPT	Long Descriptor	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
Crosswalk REF	88323	Consultation and report on referred material requiring preparation of slides	46	0.033			1.83			56				56			
Crosswalk	81406	Molecular pathology procedure, Level 7	27	0.023	0.70	1.00	1.40	1.84	2.80	60		15	38	60	83	120	
REC	81201	*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence		0.023			1.40			60				60			

Source	CPT	Long Descriptor	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	RE-TIME EVAL	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
Crosswalk REF	88291	Cytogenetics and molecular cytogenetics, interpretation and report	21	0.026			0.52			20				20			
Crosswalk	81403	Molecular pathology procedure, Level 4	47	0.028	0.40	0.52	0.77	1.00	2.50	28		10	20	28	35	60	
REC	81202	*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants		0.028			0.77			28				28			

Source	CPT	Long Descriptor	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	RE-TIME EVAL	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
Crosswalk REF	88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	31	0.022			1.18			53	8			35			10
Crosswalk	81405	Molecular pathology procedure, Level 6	31	0.031	0.52	0.80	0.94	1.40	4.50	30		10	20	30	60	80	
REC	81203	*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants		0.027			0.80			30				30			

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

3 New Molecular Pathology Services

Global Period:_XXX Meeting Date: _April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011). CAP's expert panel reviewed these cross-walked PE inputs and made minor edits in supplies for 81201 and 81203 to account for the difference in the typical service procedures.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Molecular DNA analyses based on specific code.

Intra-Service Clinical Labor Activities:

NONE

Post-Service Clinical Labor Activities:
Clean up, document filing, and other activities, see spreadsheet

	A	B	C	D
1				**81201**
2	**Meeting Date: April 2012** **Specialty: Pathology** *Typical Batch Size -* *Crosswalked to 81406 or 81295*			*APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence*
3	**---- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**129**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*111*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**118**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set-up**	L045A	Cytotechnologist	35
17	**PCR Gel (***L7: 14products)*	L045A	Cytotechnologist	20
18	**PCR Post Processing 1**	L045A	Cytotechnologist	30
19	**Post PCR Processing 2**	L045A	Cytotechnologist	20
20	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
21	**End: When specimen is ready for examination by physician**			
22	**Service Period**			
23				
24	**Post-Service Period**			
25	**Start: When specimen examination by physician is complete**			
26	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
27	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
28	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
29	Clean Room	L033A	Lab Tech	2
30	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
31	Perform scheduled data management back-up	L033A	Lab Tech	1
32	**End: When specimen, chemical waste and record handling is complete**			
33	**SUPPLIES**		**Type of Unit**	
34	DNA isolation kit		reaction	1
35	Gown	SB027	item	1
36	Gloves, nonsterile	SB022	pair	5
37	Bleach 10%	SL020	ml	1.5
38	High fidelity hot start Taq polymerase		ul	7
39	PCR buffer		ul	140
40	MgCl2		ul	42
41	F Primer X 15		ul	2
42	R Primer X 15		ul	2
43	dNTPs		ul	28
44	PCR grade water	SL244	ul	952
45	Ethidium bromide (10 mg/ml)	SL239	ul	5
46	DNA ladder, 100bp		ul	5
47	Loading buffer with dye	SL210	ul	20
48	Agarose ultrapure		g	0.8
49	Agarose NuSieve GTG		g	1.6
50	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
51	Masking tape		inch	12
52	96 Capillary array		item	1/200
53	Cycle sequencing kit		ul	224
54	Cycle sequencing purification plates		each	1
55	Optical 96 well reaction plate		each	1
56	Sequencing primers		ul	56
57	0.2 mL strip tubes		each	4
58	0.2 ml PCR tubes		each	15
59	Milli-Q water		ml	35
60	Exonuclease I / Shrimp alkaline phosphatase		ul	28
61	Septa		each	0.3
62	Sequencing cassette		each	1
63	Polymer		ul	14/125
64	Formamide	SL192	ul	420
65	15 mL centrifuge tubes	SL241		2
66	50 mL centrifuge tubes			2
67	2 mL plastic tubes		each	14

	A	B	C	D
1				**81201**
2	**Meeting Date: April 2012** **Specialty: Pathology** *Typical Batch Size -* *Crosswalked to 81406 or 81295*			*APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence*
3	**---- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Minutes**
68	Running buffer		ul	80
69	0.5 mL microcentrifuge tubes			25
70	Barrier pipet tips1000 uL		ul	4
71	Barrier pipet tips 200 uL		each	32
72	Barrier pipet tips 20uL		each	200
73	Extraction tubs		each	4
74	Extraction tip assembly		each	1
75				
76	**Equipment**			**Time in Use Minutes**
77	Analytical balance		EP004	1
78	Capillary electrophoresis instrument - sequencing			36
79	Capillary electrophoresis sequencing software			36
80	Centrifuge		EP059	3
81	Cooling block			3
82	Gel electrophoresis apparatus with power supply		EP063	15
83	Gel imaging system			4
84	Micro-volume spectrophotometer with specimen retention technology			1
85	Nucleic acid extraction instrument			5
86	Nucleic acid workstation			35
87	Pipet set		EP071	40
88	Thermal cycler			89
89	Water bath		EP043	5

	A	B	C	D
1				**81202**
2	**Meeting Date: April 2012** **Specialty: Pathology** **Crosswalk to 81221 or 81296** *Typical Batch Size - 2*			*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*			*18*
7	*Cytotechnologist*			*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	Sort and rack specimen according to test requested			
17	Place blood sample on rocker			
18	Place tips and microtiter plate on liquid handling system 1			
19	Remove cap from blood tube			
20	Place blood sample in liquid handling system 1 rack and allow instrument to read bar code and aliquot blot into microtiter plate			
21	Create plate map for testing and IT interface			
22	Cap blood tube and return specimen to refrigerator until testing completed			
23	Place tips, reagents and microtiter plates on DNA extraction instrument			
24	Place microtiter plate with blood sample on DNA extraction instrument			
25	Discard DNA extraction waste (liquids and solids)			
26	**PCR Set Up**			13
27	Assemble PCR Primers, buffer, etc… into plates			
28	Combine reagents for PCR master mix			
29	Place tips, PCR reagents and PCR reaction plate on liquid handling instrument 2			
30	Remove extracted DNA from DNA extraction instrument and place on liquid handling system 2			
31	Allow instrument to set up PCR reaction			
32	Cover plate with sealing mat			
33	Place PCR reaction plate in thermal cycler, enter PCR program, and allow instrument to perform PCR			
34	Discard liquid handling system 2 tips from PCR set up			
35	**Check gel**	L045A	Cytotechnologist	13
36	Spin down PCR plate			
37	Mix, heat, cool and pour ethidium bromide containing agarose gel			
38	Combine 8uL of PCR product with 2uL of loading buffer			
39	Add samples, controls and ladder to agarose gel			
40	Photograph gel			
41	Save image and annotate			
42	**PCR Post Processing 1**	L045A	Cytotechnologist	17
43	Prepare EXO/SAP mix			
44	Add mix to PCR products on plate			
45	Place on thermal cycler			
46	**Dye Term Cycle**	L045A	Cytotechnologist	13
47	Prepare sequencing plates			
48	Prepare sequencing Big Dye master mix			
49	Aliquot Big Dye master mix			
50	Add template			
51	Seal, vortex, spin			
52	Place on thermal cycler			

	A	B	C	D
1				**81202**
2	**Meeting Date: April 2012** **Specialty: Pathology** **Crosswalk to 81221 or 81296** *Typical Batch Size - 2*			*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*			*18*
7	*Cytotechnologist*			*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
53	**Dye Term Purification**	L045A	Cytotechnologist	24
54	Make fresh Sodium Acetate/ETOH			
55	Add to sequencing samples			
56	Spin down for 20 min			
57	Invert plate on towels			
58	Quick spin plate			
59	Make fresh 70% ETOH			
60	Add ETOH to wells			
61	Spin for 5 min			
62	Quick spin plate			
63	Add formamide and sequencing standard			
64	Cover with septa and quick spin			
65	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure “OUT” stack is empty			
66	**Sequencing**	L045A	Cytotechnologist	5
67	Load plate onto sequencer			
68	Create new sample sheet using batch name/sample number			
69	Check capillary array after run is completed			
70	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
71	**End: When specimen is ready for examination by physician**			
72	**Service Period**			
73				
74	**Post-Service Period**			
75	**Start: When specimen examination by physician is complete**			
76	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
77	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
78	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
79	Clean Room	L033A	Lab Tech	2
80	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
81	Perform scheduled data management back-up	L033A	Lab Tech	1
82	**End: When specimen, chemical waste and record handling is complete**			
83	**SUPPLIES**		**Type of Unit**	**No. of Units**
84	DNA isolation kit		reaction	1
85	Gown	SB027	item	1
86	Gloves, nonsterile	SB022	pair	5
87	Bleach 10%	SL020	ml	1.5
88	High fidelity hot start Taq polymerase		ul	0.5
89	PCR buffer		ul	10
90	MgCl2		ul	3
91	F Primer		ul	2
92	R Primer		ul	2
93	dNTPs		ul	2
94	PCR grade water	SL244	ul	68
95	Ethidium bromide (10 mg/ml)	SL239	ul	5
96	DNA ladder, 100bp		ul	5
97	Loading buffer with dye	SL210	ul	20
98	Agarose ultrapure		g	0.8
99	Agarose NuSieve GTG		g	1.6

	A	B	C	D
1				**81202**
2	**Meeting Date: April 2012** **Specialty: Pathology** **Crosswalk to 81221 or 81296** *Typical Batch Size - 2*			*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*			*18*
7	*Cytotechnologist*			*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
100	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
101	Masking tape		inch	12
102	96 Capillary array		item	1/200
103	Cycle sequencing kit		ul	16
104	Cycle sequencing purification plates		each	1
105	Optical 96 well reaction plate		each	1
106	Sequencing primers		ul	4
107	0.2 ml strip tubes		each	1
108	0.2 ml PCR tubes		each	2
109	Barrier pipet tips1000 uL		ul	1
110	Barrier pipet tips 200 uL		each	3
111	Barrier pipet tips 20uL		each	15
112	Milli-Q water		ml	35
113	Exonuclease 1 / Shrimp alkaline phosphatase		ul	4
114	Formamide	SL192	ul	30
115	Septa		each	0.3
116	Polymer		ul	1/125
117	Sequencing cassette		each	1
118	Running buffer		ul	80
119	15 mL centrifuge tubes	SL241		2
120	50 mL centrifuge tubes			2
121	2 mL plastic tubes		each	1
122	0.5 mL microcentrifuge tubes			2
123	Extraction tubs		each	4
124	Extraction tip assembly		each	1
125				
126	**Equipment**			**Time in Use Minutes**
127	Analytical balance		EP004	1
128	Capillary electrophoresis instrument, 96 well - sequencing			12
129	Centrifuge		EP059	3
130	Cooling block			3
131	Gel electrophoresis apparatus with power supply		EP063	15
132	Gel imaging system			4
133	Micro-volume spectrophotometer with specimen retention technology			1
134	Nucleic acid extraction instrument			5
135	Nucleic acid workstation			13
136	Pipet set		EP071	20
137	Thermal cycler			50
138	Water bath		EP043	10
139				
140				

	A	B	C	D
1				**81203**
2	**Meeting Date: April 2012** **Specialty: Pathology** *Typical Batch Size = 2* *All crosswalked to L2XXX6*			*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**118**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*100*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**107**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set-up**	L045A	Cytotechnologist	27
17	**PCR Gel** *(L6: 8products)*	L045A	Cytotechnologist	17
18	**PCR Post Processing 1**	L045A	Cytotechnologist	20
19	**Post PCR Processing 2**	L045A	Cytotechnologist	15
20	**Post PCR Processing 3**	L045A	Cytotechnologist	15
21	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
22	**End: When specimen is ready for examination by physician**			
23	**Service Period**			
24				
25	**Post-Service Period**			
26	**Start: When specimen examination by physician is complete**			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	**End: When specimen, chemical waste and record handling is complete**			
34	**SUPPLIES**		**Type of Unit**	
35	DNA isolation kit		reaction	1
36	Gown	SB027	item	1
37	Gloves, nonsterile	SB022	pair	5
38	Bleach 10%	SL020	ml	1.5
39	High fidelity hot start Taq polymerase		ul	4
40	PCR buffer		ul	80
41	MgCl2		ul	24
42	F Primer X 15		ul	2
43	R Primer X 15		ul	2
44	dNTPs		ul	16
45	PCR grade water	SL244	ul	544
46	Ethidium bromide (10 mg/ml)	SL239	ul	5
47	DNA ladder, 100bp		ul	5
48	Loading buffer with dye	SL210	ul	20
49	Agarose ultrapure		g	0.8
50	Agarose NuSieve GTG		g	1.6
51	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
52	Masking tape		inch	12
53	96 Capillary array		item	1/200
54				
55				
56	Optical 96 well reaction plate		each	1
57				
58	0.2 mL strip tubes		each	2
59	0.2 ml PCR tubes		each	9
60	Milli-Q water		ml	35
61				
62	Septa		each	0.3
63				
64	Polymer		ul	8/125

	A	B	C	D
1				**81203**
2	**Meeting Date: April 2012** **Specialty: Pathology** *Typical Batch Size = 2* *All crosswalked to L2XXX6*			*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
3		**CMS Code**	**Staff Type**	**Minutes**
65	Formamide	SL192	ul	240
66	15 mL centrifuge tubes	SL241		2
67	50 mL centrifuge tubes			2
68	2 mL plastic tubes		each	8
69	Running buffer		ul	80
70	0.5 mL microcentrifuge tubes			12
71	Barrier pipet tips1000 uL		ul	2
72	Barrier pipet tips 200 uL		each	18
73	Barrier pipet tips 20uL		each	120
74	Extraction tubs		each	4
75	Extraction tip assembly		each	1
76				
77				
78	**Equipment**			**Time in Use Minutes**
79	Analytical balance		EP004	1
80	Capillary electrophoresis instrument, 96 well - MLPA/Fragment			24
81	Capillary electrophoresis MLPA/Fragment software			24
82	Centrifuge		EP059	3
83	Cooling block			3
84	Gel electrophoresis apparatus with power supply		EP063	15
85	Gel imaging system			4
86	Micro-volume spectrophotometer with specimen retention technology			1
87	Nucleic acid extraction instrument			5
88	Nucleic acid workstation			27
89	Pipet set		EP071	32
90	Thermal cycler			76
91	Water bath		EP043	5

AMA/Specialty Society RVS Update Committee Summary of Recommendations

September 2011

Molecular Pathology Tier 1

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup which commenced in October 2009. In October 2010 and February 2011, the CPT Panel accepted 92 Tier 1 codes, which are analyte specific CPT codes for relatively high-volume molecular pathology services. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information, as CMS develops a policy to determine which payment schedule is appropriate for these services. In April 2011, the RUC recommended physician work and time values for 18 Tier I codes. In September 2011, the specialty presented data for the remaining services which are typically performed by a physician.

81235 EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)

The RUC reviewed the survey data from 49 molecular pathologists for CPT code 81235 *EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)* and noted that the reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU=0.52) required the same amount of time to perform as the surveyed code, 20 minutes. Further, the RUC noted that the reference code and the surveyed code are similarly intense and complex services to perform. In addition the, RUC compared the surveyed code to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (work RVU=0.38) and noted that the surveyed code requires more time to perform than this reference codes, 20 minutes and 15 minutes, respectively. Based on these comparisons, the RUC agreed with the specialty society's recommendation of 0.51 work RVUs for this service. **The RUC recommends 0.51, the survey's 25th percentile, for 81235.**

81252 GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that physician time and work effort of 81404 should be accurately assimilated to the time and work of 81252. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also

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compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code 81252.**

81253 GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons),* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that the physician time and work effort of 81403 should be accurately assimilated to the time and work of 81253. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81253.**

81254 GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)* which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. The RUC agreed that the physician time and work effort of 81401 should be accurately assimilated to the time and work of 81254. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is similarly complex and requires similar physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.40 for CPT code 81254.**

81321 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that the physician time and work effort of 81405 should be accurately assimilated to the time and work of 81321. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52),

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which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81321.**

81322 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that the physician time and work effort of 81403 should be accurately assimilated to the time and work of 81322. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81322.**

81323 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that the physician time and work effort of 81404 should be accurately assimilated to the time and work of 81323. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code 81323.**

Practice Expense

The specialty society provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However the RUC agreed that the batch sizes should be re-examined when greater experience is available for these services. Further, The specialty society explained that the majority of these services are being crosswalked with minor differences to the practice expense inputs associated with the molecular pathology services that were approved at the April 2011 RUC Meeting. The PE Subcommittee reviewed all the recommended practice expense inputs over a conference call and during the PE Subcommittee meeting and made minor changes mostly pertaining to duplication in supplies and equipment, which were all subsequently approved by the RUC.

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Work Neutrality
Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology
The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The physician time, work, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

Flagging in the RUC Database
The RUC recommends that all of the molecular pathology services with less than 30 survey responses should be flagged in the RUC database so that they are not used to validate the proposed work associated with any CPT codes under RUC review.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81235	C1	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	XXX	0.51
●81252	C2	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	XXX	0.65
●81253	C3	known familial variants	XXX	0.52

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommen-dation
●81254	C4	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	XXX	0.40
●81321	C5	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	XXX	0.80
●81322	C6	known familial variant	XXX	0.52
●81323	C7	duplication/deletion variant	XXX	0.65

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81235 Tracking Number C1 Original Specialty Recommended RVU: **0.51**
Presented Recommended RVU: **0.51**
Global Period: XXX RUC Recommended RVU: **0.51**

CPT Descriptor: EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman with no history of tobacco use presents to her physician complaining of a chronic cough. A chest x-ray reveals a right-sided peripheral lung mass, which is determined by biopsy to be adenocarcinoma of the lung. An abdominal CT scan demonstrates liver opacities, which are confirmed to be metastatic lung cancer. A tissue block is submitted for EGFR mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: Paraffin is removed and DNA is isolated from the patient's tumor tissue. DNA is subjected to 4 PCR amplification reactions for exons 18-21 of the EGFR gene. The PCR products from each exon undergo bidirectional dideoxynucleotide chain termination sequencing on a capillary electrophoresis instrument. The pathologist evaluates the electropherograms to identify nucleotide sequence variants. The pathologist composes a report which specifies the patient's EGFR mutation status, including a comment on the implications of the lower limit of detection of the test relative to the tumor content of the sample. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81235				
Sample Size:	875	**Resp N:**	49	**Response:** 5.6 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	25.00	**40.00**	100.00	600.00
Survey RVW:	0.37	0.51	**0.77**	0.94	1.83
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	15.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81235	**Recommended Physician Work RVU: 0.51**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 30.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81235**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.60
Urgency of medical decision making	3.80	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	3.93
Physical effort required	3.07	3.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	3.67
Outcome depends on the skill and judgment of physician	3.93	3.87
Estimated risk of malpractice suit with poor outcome	3.87	3.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.20	4.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81235 is greater, or as intense and complex as 88291 in 7 out of 9 measures. All intensity and complexity measures indicated a high intensity and complexity. The expert panel agreed that the median physician time of 20 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.51 appropriately values 81235 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81252 Tracking Number C2 Original Specialty Recommended RVU: **0.65**
Presented Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An otherwise healthy 2-month-old boy was found to have moderate hearing loss on newborn hearing screening. He has normal vestibular function, does not display radiographic abnormalities of the inner ear, and does not have a family history of congenital deafness or hearing loss. His physical examination is otherwise unremarkable. His physician suspects a GJB2 mutation as a possible genetic cause for his hearing loss. An anticoagulated peripheral blood sample is submitted for GJB2 sequencing to assess for the presence of DFNB1 nonsyndromic hearing loss-related mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 3 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherogram for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report which specifies the patient's GJB2 mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81252				
Sample Size:	875	**Resp N:**	8	**Response:** 0.9 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	7.00	15.00	**20.00**	53.00	150.00
Survey RVW:	0.48	0.51	**0.52**	0.52	0.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	19.00	**24.00**	30.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81252	**Recommended Physician Work RVU: 0.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 75.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81252**	**Key Reference CPT Code:** 88291	**Source of Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.17	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.33
Urgency of medical decision making	2.50	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.17	3.83
Physical effort required	3.17	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.17	3.33
Outcome depends on the skill and judgment of physician	4.17	4.00
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.67	3.50
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work with that of new tier 2 service 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.65, 30 minutes). CAP recommends a direct crosswalk of 81252 to the physician work and time of CPT code 81404, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81253 Tracking Number C3 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An otherwise healthy 1-month-old girl was found to have moderate hearing loss on newborn screening. Her older brother was found to have DFNB1 nonsyndromic hearing loss caused by 2 mutations in exon 2 of the GJB2 gene. Her physician suspects she has the same congenital hearing disorder as her brother. An anticoagulated peripheral blood sample is submitted for GJB2 exon 2 sequencing to assess for the presence of the known familial GJB2 mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherogram for the known familial variants, as well as other potential nucleotide sequence variants that may be present. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologis composes a report which specifies the patient's GJB2 mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81253				
Sample Size:	875	**Resp N:**	5	**Response:**	0.5 %
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**5.00**	10.00	25.00
Survey RVW:	0.10	0.20	**0.52**	0.52	1.39
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**15.00**	15.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81253	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.62	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81253**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**28.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.50
Physical effort required	2.58	2.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81253 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81254 Tracking Number C4 Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: GJB6 (gap junction protein, beta 6, 30kDa; connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An otherwise healthy 2-month-old boy was found to have moderate hearing loss on newborn hearing screening. He has normal vestibular function, does not display radiographic abnormalities of the inner ear, and does not have a family history of congenital deafness or hearing loss. His physical examination is otherwise unremarkable. His physician suspects a GJB2 mutation as a possible genetic cause for his hearing loss. An anticoagulated peripheral blood sample was previously submitted for GJB2 sequencing to assess for the presence of DFNB1 nonsyndromic hearing loss-related mutations, and only a single GJB2 mutation was identified. Targeted mutation testing for common GJB6 deletion mutations is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA, previously isolated from whole blood, is subjected to multiplex PCR amplification with 2 primer sets that encompass the regions of the GJB6 common variants. The fluorescently-labeled PCR products are separated by capillary electrophoresis. The pathologist evaluates the electropherogram comparing the relative sizes of the PCR product(s) to control peaks to determine the GJB6 mutation status. The composes a report which specifies the GJB6 mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81254		
Sample Size:	875	**Resp N:** 7	**Response:** 0.8 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	21.00	**24.00**	25.00	50.00
Survey RVW:	0.15	0.52	**0.52**	0.52	0.60
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	13.00	**15.00**	15.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81254	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 1 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.31	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 57.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 81254**	**Key Reference CPT Code:** 88291	**Source of Time** RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.25
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	3.25
Outcome depends on the skill and judgment of physician	4.50	4.25
Estimated risk of malpractice suit with poor outcome	3.75	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.75	3.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work with that of new tier 2 service 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)* (Recommended Work RVU = 0.40, 15 minutes). CAP recommends a direct crosswalk of 81254 to the physician work and time of CPT code 81401, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81321 Tracking Number C5 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman presents to her physician complaining of facial growths. On physical examination she is found to have multiple papular lesions in her perioral and perinasal areas, as well as on her oral mucosa. She is also noted to have macrocephaly and bilateral breast nodules. She reports having a sister with similar facial lesions. Her physician suspects she may have Cowden Syndrome. An anticoagulated peripheral blood sample is submitted for PTEN gene sequencing to assess for the presence of a Cowden Syndrome-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 9 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherogram for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report which specifies the patient's PTEN mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81321		
Sample Size:	875	**Resp N:** 4	**Response:** 0.4 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**25.00**	35.00	50.00
Survey RVW:	0.52	0.69	**0.97**	1.36	1.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	19.00	**33.00**	45.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81321	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.00	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
96406	000	0.80	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, more than 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81321**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	3.50	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	2.00	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	4.50
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	4.50	4.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81321 with that of new tier 2 service 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* (Recommended Work RVU = 0.80, 30 minutes). CAP recommends a direct crosswalk of 81321 to the physician work and time of CPT code 81405, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81322 Tracking Number C6 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old asymptomatic male patient presents to his physician for genetic testing after his mother was diagnosed with breast cancer and PTEN Hamartoma Tumor Syndrome caused by a disease-associated PTEN gene mutation. An anticoagulated peripheral blood sample from the asymptomatic male patient is submitted for testing for the known familial mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the respective PTEN exon that contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81322		
Sample Size:	875	**Resp N:** 1	**Response:** 0.1 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	0.00	0.00
Survey RVW:	0.77	0.77	**0.77**	0.77	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	35.00	35.00	**35.00**	35.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81322	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81322**	**Key Reference CPT Code:** 88182	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	1.00	1.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81322 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81322 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81323 Tracking Number C7 Original Specialty Recommended RVU: **0.65**
Presented Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man presents to his physician with multiple papular facial and oral lesions, macrocephaly, palmar and plantar keratosis, and colorectal polyposis. He reports having a sister with similar facial lesions who developed breast cancer at age 38. His physician suspects he may have PTEN Hamartoma Tumor Syndrome. PTEN gene sequencing performed to assess the patient for the presence of a PTEN Hamartoma Tumor Syndrome-related mutation did not identify a mutation. Deletion/duplication analysis of the PTEN gene is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA), which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 9 exons of the PTEN gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the PTEN gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81323		
Sample Size:	875	**Resp N:** 1	**Response:** 0.1 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	0.00	0.00
Survey RVW:	0.77	0.77	**0.77**	0.77	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	35.00	35.00	**35.00**	35.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81323	**Recommended Physician Work RVU: 0.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.00	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81323**	**Key Reference CPT Code:** 88182	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	1.00	1.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81323 with that of new tier 2 service 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.65, 30 minutes). CAP recommends a direct crosswalk of 81323 to the physician work and time of CPT code 81404, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

Molecular Pathology-Tier 1											
TAB 9											
				RVU Recommendation		**Total**				**Crosswalk**	
CPT	**Track**	**Resp**	**Long Descriptor**	**Original**	**Post Pre-Facilitation**	**Time**	**IWPUT**	**Rationale**		**Code**	**Descriptor**
81254	C4	7	GJB6 (gap junction protein, beta 6, 30kDa; connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	0.40	0.40	15	0.027	2-10 variants		81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)
81253	C3	5	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	0.52	0.52	28	0.019	Single exon sequencing		81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
81322	C6	1	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	0.52	0.52	28	0.019	Single exon sequencing		81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
81235	C1	49	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	0.51	0.51	20	0.026	2-5 sequence analysis		81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
81252	C2	8	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	0.65	0.65	30	0.022	2-5 sequence analysis		81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
81323	C7	1	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	0.65	0.65	30	0.022	6-10 exon sequencing		81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
81321	C5	4	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	0.80	0.80	30	0.027	6-10 exon sequencing		81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

59 New Molecular Pathology Services

Global Period:_XXX Meeting Date: _September 2011

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

TAB 5 – All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011), except for the HLA code set where CAP surveyed several large and small labs throughout the United States. Survey responses were compiled; questions and clarifications were followed up with lab managers and directors. CAP's expert panel reviewed compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment for all codes.

TAB 9 – All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011).

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Molecular DNA analyses based on specific code.

Intra-Service Clinical Labor Activities:

NONE

Post-Service Clinical Labor Activities:
Clean up, document filing, and other activities, see spreadsheet

	A	B	C	D
1	TAB 9			**81235**
2	**Meeting Date: September 2011** *Typical Batch Size - 2* *Cross walk from (DNA extraction from parriffin)*			*EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)*
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**111**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*93*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**100**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction - Added 2 minutes**	L045A	Cytotechnologist	6
16	Cutting sections from specimen block using microtome			
17	Removal of paraffin			
18	DNA extraction using extraction instrument			
19	Dilution of DNA extraction 1:5 or 1:10			
20	**PCR Set-up**	L045A	Cytotechnologist	25
21	**PCR Gel** *(L5: 4products)*	L045A	Cytotechnologist	15
22	**PCR Post Processing**	L045A	Cytotechnologist	45
23	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
24	**End: When specimen is ready for examination by physician**			
25	**Service Period**			
26				
27	**Post-Service Period**			
28	**Start: When specimen examination by physician is complete**			
29	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
30	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
31	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
32	Clean Room	L033A	Lab Tech	2
33	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
34	Perform scheduled data management back-up	L033A	Lab Tech	1
35	**End: When specimen, chemical waste and record handling is complete**			
36	**SUPPLIES**		**Type of Unit**	**No. of Units**
37	DNA isolation kit		reaction	1
38	Gown	SB027	item	1
39	Gloves, nonsterile	SB022	pair	5
40	Bleach 10%	SL020	ml	1.5
41	High fidelity hot start Taq polymerase		ul	2
42	PCR buffer		ul	40
43	MgCl2		ul	12
44	F Primer X 4		ul	2
45	R Primer X 4		ul	2
46	dNTPs		ul	8
47	PCR grade water	SL244	ul	272
48	Ethidium bromide (10 mg/ml)	SL239	ul	5
49	DNA ladder, 100bp		ul	5
50	Loading buffer with dye	SL210	ul	20
51	Agarose ultrapure		g	0.8

	A	B	C	D
1	TAB 9			**81235**
2	**Meeting Date: September 2011** *Typical Batch Size - 2* *Cross walk from (DNA extraction from parriffin)*			*EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)*
3		**CMS Code**	**Staff Type**	**Minutes**
52	Agarose NuSieve GTG		g	1.6
53	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
54	Masking tape		inch	12
55	96 Capillary array		item	1/200
56	Cycle sequencing kit		ul	64
57	Cycle sequencing purification plates		each	1
58	Optical 96 well reaction plate		each	1
59	Sequencing primers		ul	16
60	0.2 mL strip tubes		each	1
61	0.2 ml PCR tubes		each	5
62	Milli-Q water		ml	35
63	Exonuclease I / Shrimp alkaline phosphatase		ul	8
64	Septa		each	0.3
65	Sequencing cassette		each	1
66	Polymer		ul	4/125
67	Formamide	SL192	ul	120
68	15 mL centrifuge tubes	SL241		2
69	50 mL centrifuge tubes			2
70	2 mL plastic tubes		each	4
71	Running buffer		ul	80
72	0.5 mL microcentrifuge tubes			6
73	Barrier pipet tips1000 uL		ul	1
74	Barrier pipet tips 200 uL		each	9
75	Barrier pipet tips 20uL		each	60
76	Extraction tubs		each	4
77	Extraction tip assembly		each	1
78	100% ethanol	SL189	ml	50
79	Xylene	SL151	ml	50
80	Micro tubes 2.0 mL		item	2
81	Micro tubes, 1.5 mL with caps		item	4
82	Microtube, 1.5 mL with locking lid		item	1
83	Gauze, 4 x 4	SG051	item	1
84	Kimwipe	SM027	item	2
85				
86	**Equipment**			**Time in Use Minutes**
87	Analytical balance		EP004	1
88	Capillary electrophoresis instrument, 96 well - sequencing			12
89	Capillary electrophoresis sequencing software			12
90	Centrifuge		EP059	3
91	Cooling block			3
92	Gel electrophoresis apparatus with power supply		EP063	15
93	Gel imaging system		EP062	4
94	Micro-volume spectrophotometer with specimen retention technology			1
95	Nucleic acid extraction instrument			5
96	Nucleic acid workstation			25
97	Pipet set		EP071	30
98	Thermal cycler			63
99	Water bath		EP043	5
100	Solvent recycler system			2

	A	B	C	D
1	**TAB 9**			**81252**
2	**Meeting Date: September 2011**			GJB2(gap junction protein, beta 2, 26kDa; connexin 26)(eg, nonsyndromic hearing loss) gene analysis; full gene sequence
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**75**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*57*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**64**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	Extraction (run set up)			
17	Extraction (aliquoting, instrument set up, DNA concentration)			
18	**PCR Set Up**	L045A	Cytotechnologist	13
19	Generate run on computer, generate a run on computer, and prepare tray map			
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)			
21	Retrieve sample, position on tray map			
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix			
23	Aliqout mastermix and sample to well			
24	Vortex and spin sample			
25	Set up Thermocycler and load samples			
26	Remove samples from thermocycler			
27	**PCR Gel**	L045A	Cytotechnologist	13
28	Prepare Gel			
29	Load Gel			
30	Gel and Label picture			
31	**PCR Post Processing**	L045A	Cytotechnologist	25
32	Post-PCR -Prepare loading master mix			
33	Dilute sample			
34	Denature/cool samples			
35	Load sample onto instrument			
36	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
37	**End: When specimen is ready for examination by physician**			
38	**Service Period**			
39				
40	**End: When specimen is ready for examination by physician**			
41	**Post-Service Period**			
42	**Start: When specimen examination by physician is complete**			
43	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
44	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
46	Clean Room	L033A	Lab Tech	2
47	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
48	Perform scheduled data management back-up	L033A	Lab Tech	1
49	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	**TAB 9**			**81252**
2	**Meeting Date: September 2011**			GJB2(gap junction protein, beta 2, 26kDa; connexin 26)(eg, nonsyndromic hearing loss) gene analysis; full gene sequence
3		**CMS Code**	**Staff Type**	**Minutes**
50	**SUPPLIES**		**Type of Unit**	**No. of Units**
51	DNA isolation kit		reaction	1
52	Gown	SB027	item	0.5
53	Gloves, nonsterile	SB022	pair	2.5
54	Bleach 10%	SL020	ml	0.75
55	High fidelity hot start Taq polymerase		ul	0.75
56	PCR buffer		ul	15
57	MgCl2		ul	4.5
58	F Primer, fluorescent		ul	3
59	R Primer, fluorescent		ul	3
60	dNTPs		ul	3
61	PCR grade water	SL244	ul	102
62	Ethidium bromide (10 mg/ml)	SL239	ul	5
63	DNA ladder, 100bp		ul	5
64	Loading buffer with dye	SL210	ul	20
65	Agarose ultrapure		g	0.8
66	Agarose NuSieve GTG		g	1.6
67	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
68	Milli-Q water		ml	40
69	Masking tape		inch	12
70	0.2 mL strip tubes		each	2
71	0.5 mL microcentrifuge tubes			2
72	2 mL plastic tubes		each	2
73	PCR grade water	SL244	ul	228
74	Barrier pipet tips1000 uL		ul	1
75	Barrier pipet tips 200 uL		each	3
76	Barrier pipet tips 20uL		each	10
77	Running buffer		ul	10
78	Formamide	SL192	ul	30
79	Size standard		ul	2.6
80	Optical 96 well reaction plate		each	1
81	Septa		each	0.3
82	Polymer		ul	2/125
83	Capillary array		item	1/200
84	Cassette		each	1
85	Extraction tubs		each	4
86	Extraction tip assembly		each	1
87				
88	**Equipment**			**Time in Use Minutes**
89	Analytical balance		EP004	1
90	Capillary electrophoresis instrument - sequencing analysis			15
91	Capillary electrophoresis instrument - sequencing analysis software			15
92	Centrifuge		EP059	2
93	Cooling block			1
94	Gel electrophoresis apparatus with power supply		EP063	8
95	Gel imaging system		EP062	2
96	Micro-volume spectrophotometer with specimen retention technology			1
97	Nucleic acid extraction instrument			5
98	Nucleic acid workstation			13
99	Pipet set		EP071	14
100	Thermal cycler			25
101	Water bath		EP043	5

	A	B	C	D	E
1	**TAB 9**			**81322**	**81254**
2	**Meeting Date: September 2011** **Crosswalk to 88XX8** *Typical Batch Size - 2*			PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; known familial variants	GJB2(gap junction protein, beta 2, 26kDa; connexin 26)(eg, nonsyndromic hearing loss) gene analysis; known familial variants
3	**- DIRECT CROSSWALK --**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**
6	*Lab Tech*			*18*	*18*
7	*Cytotechnologist*			*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
11	**PRE-SERVICE**				
12	**Start: When preparing containers/requisitions for physician begins**				
13	**Confirm** orders	L033A	Lab Tech	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4
16	Sort and rack specimen according to test requested				
17	Place blood sample on rocker				
18	Place tips and microtiter plate on liquid handling system 1				
19	Remove cap from blood tube				
20	Place blood sample in liquid handling system 1 rack and allow instrument to read bar code and aliquot blot into microtiter plate				
21	Create plate map for testing and IT interface				
22	Cap blood tube and return specimen to refrigerator until testing completed				
23	Place tips, reagents and microtiter plates on DNA extraction instrument				
24	Place microtiter plate with blood sample on DNA extraction instrument				
25	Discard DNA extraction waste (liquids and solids)				
26	**PCR Set Up**			13	13
27	Assemble PCR Primers, buffer, etc… into plates				
28	Combine reagents for PCR master mix				
29	Place tips, PCR reagents and PCR reaction plate on liquid handling instrument 2				
30	Remove extracted DNA from DNA extraction instrument and place on liquid handling system 2				
31	Allow instrument to set up PCR reaction				
32	Cover plate with sealing mat				
33	Place PCR reaction plate in thermal cycler, enter PCR program, and allow instrument to perform PCR				
34	Discard liquid handling system 2 tips from PCR set up				
35	**Check gel**	L045A	Cytotechnologist	13	13
36	Spin down PCR plate				
37	Mix, heat, cool and pour ethidium bromide containing agarose gel				
38	Combine 8uL of PCR product with 2uL of loading buffer				
39	Add samples, controls and ladder to agarose gel				
40	Photograph gel				
41	Save image and annotate				

	A	B	C	D	E
1	**TAB 9**			**81322**	**81254**
2	**Meeting Date: September 2011** **Crosswalk to 88XX8** *Typical Batch Size - 2*			PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; known familial variants	GJB2(gap junction protein, beta 2, 26kDa; connexin 26)(eg, nonsyndromic hearing loss) gene analysis; known familial variants
3	**- DIRECT CROSSWALK --**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**
6	*Lab Tech*			*18*	*18*
7	*Cytotechnologist*			*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
42	**PCR Post Processing 1**	L045A	Cytotechnologist	17	17
43	Prepare EXO/SAP mix				
44	Add mix to PCR products on plate				
45	Place on thermal cycler				
46	**Dye Term Cycle**	L045A	Cytotechnologist	13	13
47	Prepare sequencing plates				
48	Prepare sequencing Big Dye master mix				
49	Aliquot Big Dye master mix				
50	Add template				
51	Seal, vortex, spin				
52	Place on thermal cycler				
53	**Dye Term Purification**	L045A	Cytotechnologist	24	24
54	Make fresh Sodium Acetate/ETOH				
55	Add to sequencing samples				
56	Spin down for 20 min				
57	Invert plate on towels				
58	Quick spin plate				
59	Make fresh 70% ETOH				
60	Add ETOH to wells				
61	Spin for 5 min				
62	Quick spin plate				
63	Add formamide and sequencing standard				
64	Cover with septa and quick spin				
65	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure “OUT” stack is empty				
66	**Sequencing**	L045A	Cytotechnologist	5	5
67	Load plate onto sequencer				
68	Create new sample sheet using batch name/sample number				
69	Check capillary array after run is completed				
70	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
71	**End: When specimen is ready for examination by physician**				
72	**Service Period**				
73					
74	**Post-Service Period**				
75	**Start: When specimen examination by physician is complete**				
76	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
77	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
78	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
79	Clean Room	L033A	Lab Tech	2	2
80	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
81	Perform scheduled data management back-up	L033A	Lab Tech	1	1
82	**End: When specimen, chemical waste and record handling is complete**				
83	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
84	DNA isolation kit		reaction	1	1
85	Gown	SB027	item	1	1
86	Gloves, nonsterile	SB022	pair	5	5
87	Bleach 10%	SL020	ml	1.5	1.5
88	High fidelity hot start Taq polymerase		ul	0.5	0.5
89	PCR buffer		ul	10	10
90	MgCl2		ul	3	3
91	F Primer		ul	2	2
92	R Primer		ul	2	2
93	dNTPs		ul	2	2
94	PCR grade water	SL244	ul	68	68
95	Ethidium bromide (10 mg/ml)	SL239	ul	5	5
96	DNA ladder, 100bp		ul	5	5

	A	B	C	D	E
1	**TAB 9**			**81322**	**81254**
2	**Meeting Date: September 2011** **Crosswalk to 88XX8** *Typical Batch Size - 2*			PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; known familial variants	GJB2(gap junction protein, beta 2, 26kDa; connexin 26)(eg, nonsyndromic hearing loss) gene analysis; known familial variants
3	**- DIRECT CROSSWALK --**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**
6	*Lab Tech*			*18*	*18*
7	*Cytotechnologist*			*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
97	Loading buffer with dye	SL210	ul	20	20
98	Agarose ultrapure		g	0.8	0.8
99	Agarose NuSieve GTG		g	1.6	1.6
100	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100
101	Masking tape		inch	12	12
102	96 Capillary array		item	1/200	1/200
103	Cycle sequencing kit		ul	16	16
104	Cycle sequencing purification plates		each	1	1
105	Optical 96 well reaction plate		each	1	1
106	Sequencing primers		ul	4	4
107	0.2 ml strip tubes		each	1	1
108	0.2 ml PCR tubes		each	2	2
109	Barrier pipet tips1000 uL		ul	1	1
110	Barrier pipet tips 200 uL		each	3	3
111	Barrier pipet tips 20uL		each	15	15
112	Milli-Q water		ml	35	35
113	Exonuclease 1 / Shrimp alkaline phosphatase		ul	4	4
114	Formamide	SL192	ul	30	30
115	Septa		each	0.3	0.3
116	Polymer		ul	1/125	1/125
117	Sequencing cassette		each	1	1
118	Running buffer		ul	80	80
119	15 mL centrifuge tubes	SL241		2	2
120	50 mL centrifuge tubes			2	2
121	2 mL plastic tubes		each	1	1
122	0.5 mL microcentrifuge tubes			2	2
123	Extraction tubs		each	4	4
124	Extraction tip assembly		each	1	1
125					
126	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
127	Analytical balance		EP004	1	1
128	Capillary electrophoresis instrument, 96 well - sequencing			12	12
129	Centrifuge		EP059	3	3
130	Cooling block			3	3
131	Gel electrophoresis apparatus with power supply		EP063	15	15
132	Gel imaging system		EP062	4	4
133	Micro-volume spectrophotometer with specimen retention technology			1	1
134	Nucleic acid extraction instrument			5	5
135	Nucleic acid workstation			13	13
136	Pipet set		EP071	20	20
137	Thermal cycler			50	50
138	Water bath		EP043	10	10

	A	B	C	D
1	**TAB 9**			**81254**
2	**Meeting Date: September 2011** **Crosswalk to L2** *Adjusted for Batch Size - 4*			*GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])*
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**62**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*44*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**51**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	Extraction (run set up)			
17	Extraction (aliquoting, instrument set up, DNA concentration)			
18	**PCR Set Up**	L045A	Cytotechnologist	13
19	Generate run on computer, generate a run on computer, and prepare tray map			
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)			
21	Retrieve sample, position on tray map			
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix			
23	Aliqout mastermix and sample to well			
24	Vortex and spin sample			
25	Set up Thermocycler and load samples			
26	Remove samples from thermocycler			
27	**PCR Gel --- DELETED**	L045A	Cytotechnologist	X
28	Prepare Gel --- DELETED			X
29	Load Gel --- DELETED			X
30	Gel and Label picture --- DELETED			X
31	**PCR Post Processing**	L045A	Cytotechnologist	25
32	Post-PCR -Prepare loading master mix			
33	Dilute sample			
34	Denature/cool samples			
35	Load sample onto instrument			
36	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
37	**End: When specimen is ready for examination by physician**			
38	**Service Period**			
39				
40	**End: When specimen is ready for examination by physician**			
41	**Post-Service Period**			
42	**Start: When specimen examination by physician is complete**			
43	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
44	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
46	Clean Room	L033A	Lab Tech	2
47	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
48	Perform scheduled data management back-up	L033A	Lab Tech	1
49	**End: When specimen, chemical waste and record handling is complete**			
50	**SUPPLIES**		**Type of Unit**	**No. of Units**
51	DNA isolation kit		reaction	1
52	Gown	SB027	item	0.5
53	Gloves, nonsterile	SB022	pair	2.5
54	Bleach 10%	SL020	ml	0.75
55	High fidelity hot start Taq polymerase		ul	0.75
56	PCR buffer		ul	15
57	MgCl2		ul	4.5

	A	B	C	D
1	**TAB 9**			**81254**
2	**Meeting Date: September 2011** **Crosswalk to L2** *Adjusted for Batch Size - 4*			*GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])*
3		**CMS Code**	**Staff Type**	**Minutes**
58	F Primer, fluorescent		ul	3
59	R Primer, fluorescent		ul	3
60	dNTPs		ul	3
61	PCR grade water	SL244	ul	102
62	Ethidium bromide (10 mg/ml)	SL239	ul	5
63	DNA ladder, 100bp - DELETED		ul	X
64	Loading buffer with dye - DELETED	SL210	ul	X
65	Agarose ultrapure - DELETED		g	X
66	Agarose NuSieve GTG -- DELETED		g	X
67	1X TBE Buffer (Tris, Boric Acid, EDTA) -- DELETED		ml	X
68	Milli-Q water		ml	40
69	Masking tape - DELETED		inch	X
70	0.2 mL strip tubes		each	2
71	0.5 mL microcentrifuge tubes			2
72	2 mL plastic tubes		each	2
73	PCR grade water	SL244	ul	228
74	Barrier pipet tips1000 uL		ul	1
75	Barrier pipet tips 200 uL		each	3
76	Barrier pipet tips 20uL		each	10
77	Running buffer		ul	10
78	Formamide	SL192	ul	30
79	Size standard		ul	2.6
80	Optical 96 well reaction plate		each	1
81	Septa		each	0.3
82	Polymer		ul	3:40
83	Capillary array		item	1/200
84	Cassette		each	1
85	Extraction tubs		each	4
86	Extraction tip assembly		each	1
87				
88	**Equipment**			**Time in Use Minutes**
89	Analytical balance		EP004	1
90	Capillary electrophoresis instrument - fragment analysis			15
91	Capillary electrophoresis instrument - fragment analysis software			15
92	Centrifuge		EP059	2
93	Cooling block			1
94	Gel electrophoresis apparatus with power supply		EP063	8
95	Gel imaging system		EP062	2
96	Micro-volume spectrophotometer with specimen retention technology			1
97	Nucleic acid extraction instrument			5
98	Nucleic acid workstation			13
99	Pipet set		EP071	14
100	Thermal cycler			25
101	Water bath		EP043	5

	A	B	C	D
1	**TAB 9**			**81321**
2	**Meeting Date: September 2011** *Typical Batch Size = 2* *All crosswalked to L2XXX6*			*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; full sequence analysis*
3	**----- DIRECT CROSSWALK ---**	**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**118**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*100*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**107**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotech	4
16	**PCR Set-up**	L045A	Cytotech	27
17	**PCR Gel** *(L6: 8products)*	L045A	Cytotech	17
18	**PCR Post Processing 1**	L045A	Cytotech	20
19	**Post PCR Processing 2**	L045A	Cytotech	15
20	**Post PCR Processing 3**	L045A	Cytotech	15
21	**Review sample and prepare data for physician interpretation**	L045A	Cytotech	2
22	**End: When specimen is ready for examination by physician**			
23	**Service Period**			
24				
25	**Post-Service Period**			
26	**Start: When specimen examination by physician is complete**			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	**End: When specimen, chemical waste and record handling is complete**			
34				
35	**SUPPLIES**		**Type of Unit**	
36	DNA isolation kit		reaction	1
37	Gown	SB027	item	1
38	Gloves, nonsterile	SB022	pair	5
39	Bleach 10%	SL020	ml	1.5
40	High fidelity hot start Taq polymerase		ul	4
41	PCR buffer		ul	80
42	MgCl2		ul	24
43	F Primer X 8		ul	2
44	R Primer X 8		ul	2
45	dNTPs		ul	16
46	PCR grade water	SL244	ul	544
47	Ethidium bromide (10 mg/ml)	SL239	ul	5
48	DNA ladder, 100bp		ul	5
49	Loading buffer with dye	SL210	ul	20
50	Agarose ultrapure		g	0.8
51	Agarose NuSieve GTG		g	1.6
52	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
53	Masking tape		inch	12
54	96 Capillary array		item	1/200
55	Cycle sequencing kit		ul	128
56	Cycle sequencing purification plates		each	1
57	Optical 96 well reaction plate		each	1
58	Sequencing primers		ul	32
59	0.2 mL strip tubes		each	2
60	0.2 ml PCR tubes		each	9
61	Milli-Q water		ml	35

	A	B	C	D
1	**TAB 9**			**81321**
2	**Meeting Date: September 2011** *Typical Batch Size = 2* *All crosswalked to L2XXX6*			*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; full sequence analysis*
3	**----- DIRECT CROSSWALK ---**	**CMS Code**	**Staff Type**	**Minutes**
62	Exonuclease I / Shrimp alkaline phosphatase		ul	16
63	Septa		each	0.3
64	Sequencing cassette		each	1
65	Polymer		ul	8/125
66	Formamide	SL192	ul	240
67	15 mL centrifuge tubes	SL241		2
68	50 mL centrifuge tubes			2
69	2 mL plastic tubes		each	8
70	Running buffer		ul	80
71	0.5 mL microcentrifuge tubes			12
72	Barrier pipet tips1000 uL		ul	2
73	Barrier pipet tips 200 uL		each	18
74	Barrier pipet tips 20uL		each	120
75	Extraction tubs		each	4
76	Extraction tip assembly		each	1
77	**Equipment**			**Time in Use Minutes**
78	Analytical balance		EP004	1
79	Capillary electrophoresis instrument, 96 well - sequencing			24
80	Capillary electrophoresis sequencing software			24
81	Centrifuge		EP059	3
82	Cooling block			3
83	Gel electrophoresis apparatus with power supply		EP063	15
84	Gel imaging system		EP062	4
85	Micro-volume spectrophotometer with specimen retention technology			1
86	Nucleic acid extraction instrument			5
87	Nucleic acid workstation			27
88	Pipet set		EP071	32
89	Thermal cycler			76
90	Water bath		EP043	5

	A	B	C	D
1	**Tab 9**			**81323**
2	**Meeting Date: September 2011** *Typical Batch Size = 2* *Crosswalked to L2XXX5*			*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; duplication/deletion variant*
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set-up**	L045A	Cytotechnologist	25
17	**PCR Gel** *(L5: 4products)*	L045A	Cytotechnologist	15
18	**PCR Post Processing**	L045A	Cytotechnologist	45
19	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
20	**End: When specimen is ready for examination by physician**			
21	**Service Period**			
22				
23	**Post-Service Period**			
24	**Start: When specimen examination by physician is complete**			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	**End: When specimen, chemical waste and record handling is complete**			
32				
33	**SUPPLIES**		**Type of Unit**	**No. of Units**
34	DNA isolation kit		reaction	1
35	Gown	SB027	item	1
36	Gloves, nonsterile	SB022	pair	5
37	Bleach 10%	SL020	ml	1.5
38	High fidelity hot start Taq polymerase		ul	2
39	PCR buffer		ul	40
40	MgCl2		ul	12
41	F Primer X 4		ul	2
42	R Primer X 4		ul	2
43	dNTPs		ul	8
44	PCR grade water	SL244	ul	272
45	Ethidium bromide (10 mg/ml)	SL239	ul	5
46	DNA ladder, 100bp		ul	5
47	Loading buffer with dye	SL210	ul	20
48	Agarose ultrapure		g	0.8
49	Agarose NuSieve GTG		g	1.6
50	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
51	Masking tape		inch	12
52	96 Capillary array		item	1/200
53	Cycle sequencing kit --- DELETED		ul	
54	Cycle sequencing purification plates --- DELETED		each	
55	Optical 96 well reaction plate		each	1
56	Sequencing primers --- DELETED		ul	
57	0.2 mL strip tubes		each	1
58	0.2 ml PCR tubes		each	5
59	Milli-Q water		ml	35
60	Exonuclease I / Shrimp alkaline phosphatase --- DELETED		ul	
61	Septa		each	0.3

	A	B	C	D
1	**Tab 9**			**81323**
2	**Meeting Date: September 2011** *Typical Batch Size = 2* *Crosswalked to L2XXX5*			*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTENhamartoma tumor syndrome) gene analysis; duplication/deletion variant*
3		**CMS Code**	**Staff Type**	**Minutes**
62	Sequencing cassette --- DELETED		each	
63	Polymer		ul	4/125
64	Formamide	SL192	ul	120
65	15 mL centrifuge tubes	SL241		2
66	50 mL centrifuge tubes			2
67	2 mL plastic tubes		each	4
68	Running buffer		ul	80
69	0.5 mL microcentrifuge tubes			6
70	Barrier pipet tips1000 uL		ul	1
71	Barrier pipet tips 200 uL		each	9
72	Barrier pipet tips 20uL		each	60
73	Extraction tubs		each	4
74	Extraction tip assembly		each	1
75				
76	**Equipment**			**Time in Use Minutes**
77	Analytical balance		EP004	1
78	Capillary electrophoresis instrument, 96 well			12
79	Capillary electrophoresis fragment analysis software			12
80	Centrifuge		EP059	3
81	Cooling block			3
82	Gel electrophoresis apparatus with power supply		EP063	15
83	Gel imaging system		EP062	4
84	Micro-volume spectrophotometer with specimen retention technology			1
85	Nucleic acid extraction instrument			5
86	Nucleic acid workstation			25
87	Pipet set		EP071	30
88	Thermal cycler			63
89	Water bath		EP043	5

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Cell Enumeration Circulating Tumor Cells

In February 2012, the CPT Editorial Panel created two new CPT codes 86152 and 86153 to describe cell enumeration of circulating tumor cells in fluid specimens using an immunologic method and deleted the previous category III codes that described this service (0279T and 0280T). CPT code 86152 will be paid on the Clinical Laboratory Fee Schedule.

86153 ***Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood):*** **physician interpretation and report, when required**
The RUC reviewed the survey data from 36 pathologists and recommends the following physician work time components: intra-service time= 20 minutes and post-service time= 5 minutes. The specialty explained that the methodology used to survey this procedure involved a general subset of the College of American Pathologists (CAP) membership and a specified list of users supplied by the vendor of the test. Of the 36 survey respondents, 21 were from the vendor list. The RUC agreed that the survey results obtained from the vendor list is more representative of the typical practice of the interpretation and report of circulating tumor cells. Physicians' in this group are experienced and more attuned to the service provided than the group of 15 randomly selected CAP members. Therefore, the RUC agreed that a work RVU of 0.69, the 25th percentile survey results from the vendor's list, accurately reflects the physician work involved in this service.

To justify a work value of 0.69, the RUC reviewed CPT code 88305 *Level IV Surgical pathology, gross and microscopic examination* (work RVU= 0.75) and agreed that the reference code should be valued slightly higher due to greater intra-service time compared to 86153, 25 minutes and 20 minutes, respectively. In addition, the RUC compared the surveyed code to CPT code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU= 0.69) and agreed that these two similar pathology services should be valued the same given analogous physician work and intensity. **The RUC recommends a work RVU of 0.69 for CPT code 86153.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

New Technology: This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 86152		Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); (For physician interpretation and report, use 86153. For cell enumeration with interpretation and report, use 86152 and 86153)	XXX	Paid on the Clinical Lab Fee Schedule
● 86153	W1	physician interpretation and report, when required (For cell enumeration use 86152. For cell enumeration with interpretation and report, use 86152 and 86153) (For flow cytometric immunophenotyping see 88184-88189 or flow cytometric quantitation see 86355, 86356, 86357, 86359, 86360, 86361, 86367)	XXX	0.69
(e)86148		Anti-phosphatidylserine (phospholipid) antibody (To report antiprothrombin [phospholipid cofactor] antibody, use Category III code 0030T) (~~For cell enumeration using immunologic selection and identification in fluid specimen [eg, tumor cells in blood, see 0279T, 0280T~~)		
D0279T		~~Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);~~	XXX	Carrier Price

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D0280T		~~interpretation and report~~ ~~(Use 0280T in conjunction with 0279T)~~ ~~(For flow cytometric immunophenotyping, see 88184-88189. For flow cytometric quantitation, see 86355-86357, 86359-86361, 86367)~~ (Category III codes 0279T, 0280T have been deleted. To report, see 86152, 86153)	XXX	Carrier Price

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February 29, 2012

Barbara Lewis, DO
Chair
Research Subcommittee
RVS Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

RE: Survey Methodology for 8615X2

Dear Doctor Lewis;

The CAP requests that the Research Subcommittee approve a panel survey methodology for code 86153 *Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required.* This service is not typically performed by general pathologists but is currently performed mainly by specialized pathologists in academic settings. This is a service that is performed by very few pathologists. Rather than send surveys to a completely random sample of our membership, we believe that our society will be able to provide the RUC with the most accurate data by surveying physicians that we know perform this service, and supplement with that list a random subset of our membership. This would not be then considered a complete random sample, however it will enable us to obtain a useful number of survey responses and identify how frequently the service is performed by our general membership.

We have obtained a user list from the manufacturers of the equipment used in performing this service. The physicians on this list are familiar with, and best able to measure the physician work of performing this service. We request that we be permitted to include this group as survey participants.

If you have any questions or concerns, please contact, Todd Klemp, Assistant Director of Economic and Regulatory Affairs at (202) 354-7403 or tklemp@cap.org

Sincerely,

Jonathan L. Myles, MD, FCAP
RUC Advisor
College of American Pathologists

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:86153 Tracking Number W1 Original Specialty Recommended RVU: **0.69**
Presented Recommended RVU: **0.69**
Global Period: XXX RUC Recommended RVU: **0.69**

CPT Descriptor: Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required

(For cell enumeration use 86152. For cell enumeration with interpretation and report, use 86152 and 86153)
(For flow cytometric immunophenotyping see 88184-88189 or flow cytometric quantitation see 86355, 86356, 86357, 86359, 86360, 86361, 86367)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A woman with metastatic breast cancer presents to her physician for follow-up. Results of the cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood) require interpretation by physician.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The physician examines the entire image file and classifies circulating cells as epithelial tumor cells, white blood cells, or other, based on strict cytomorphological criteria and experience in fluorescent microscopy and reviews relevant findings in the patient's case history. The physician prepares and signs an interpretive written report.

Description of Post-Service Work: Written and telephone communications with patients and/or referring physician and arranging for further studies or other services after finalization of report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jonathan Myles, MD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	86153		
Sample Size:	5065	**Resp N:** 36	**Response:** 0.7 %
Description of Sample:	Random and select lists		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	20.00	**50.00**	125.00	800.00
Survey RVW:	0.20	0.77	**1.14**	1.77	2.80
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	86153	**Recommended Physician Work RVU: 0.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88361	XXX	1.18	**RUC Time**

CPT Descriptor Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97002	XXX	0.60	**RUC Time**	406,764

CPT Descriptor 1 Physical therapy re-evaluation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99462	XXX	0.84	**RUC Time**	7

CPT Descriptor 2 Subsequent hospital care, per day, for evaluation and management of normal

Other Reference CPT Code	Global	Work RVU	Time Source
88172	XXX	0.69	**RUC Time**

CPT Descriptor Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 86153**	**Key Reference CPT Code:** 88361	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	40.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**25.00**	**40.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.50
Urgency of medical decision making	3.64	3.53
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.78	3.88
Physical effort required	3.22	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.28	3.61
Outcome depends on the skill and judgment of physician	3.83	3.81
Estimated risk of malpractice suit with poor outcome	3.00	3.36

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.58	3.64
Post-Service intensity/complexity	3.58	3.61

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This service is not typically performed by general pathologists but is currently performed mainly by specialized pathologists in academic settings. This is a service that is performed by very few pathologists. Rather than send surveys to a completely random sample of our membership, we believed that our society will be able to provide the RUC with the most accurate data by surveying physicians that we know perform this service, and supplement with that list a

random subset of our membership. Therefore, our survey was not completely random. It did however enable us to obtain a useful number of survey responses.

In February 2012, the RUC's Research Subcommittee agreed with CAP's survey methodology. CAP surveyed a large subset of its membership (4,974) and a user list supplied by the vendor of the test used in performing this service (91). CAP obtained a total of 36 responses to the survey. 15 responses were from the random CAP membership lists and 21 from the manufacturer's user list. The survey results were robust in total and among the two groups of participants.

CAP's relative value workgroup, CAP's RUC advisor, and representatives from the general and academic pathology practice settings reviewed the survey results. The survey results obtained from the random CAP membership proved to be slightly higher in time and estimated physician work than pathologists most familiar to this service (vendor group). CAP's expert panel believes the data obtained from the latter group is more representative of the typical practice of the interpretation and report of circulating tumor cells. Physicians' in this group may be more experienced and more attuned to the service provided than the group of 15 randomly selected CAP members.

CAP's expert panel recommends to the RUC a physician work relative value of 0.69. 0.69 RVW is the 25th percentile survey result from the vendor's user list of respondents and provides proper rank order of this service with other services within pathology and across other specialty services on the physician fee schedule. A work RVU of 0.69 is between than the 25th percentile and the low of the combined survey results.

CAP recommends; a work RVU = 0.69, intra-service time = 20 minutes, and immediate post time = 5 minutes.

CAP's expert panel believes a work RVU of 0.69 for CPT code 86153 is appropriate as it provides proper rank order with the following CPT codes:
88305 Level IV - Surgical pathology, gross and microscopic examination… **(work RVU = 0.75, intra-service time = 25, IWPUT = 0.300)**

88334 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure) **(work RVU = 0.73, intra-service time = 20 minutes, IWPUT = 0.0365)**

88172 Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site **(work RVU = 0.69, intra-service time = 20 minutes, IWPUT = 0.0345)**

88387 Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node) **(work RVU = 0.62, intra-service time = 20, IWPUT = 0.0310)**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) 86152 is used to report only the physician interpretation and report for the Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This service would follow 8615X1 Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); which has been proposed to be valued on the Clinical Lab Fee Schedule.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 86849 Immunology procedure
89240 Unlisted miscellaneous pathology
S3711 Circulating tumor cell test

Effective January 1, 2012, Category III codes are being used.
0279T Cell enumeration using immunologic selection and identification in fluid specimen (e.g., circulating tumor cells in blood);
0280T Interpretation and report

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty Oncology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 157500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on current product sales and forecasts

Specialty Pathology Frequency 141750 Percentage 90.00 %

Specialty Oncology Frequency 15750 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates in 2010 are: 89240- 4700 & 86849-1300

Specialty Pathology Frequency 5400 Percentage 90.00 %

Specialty Oncology Frequency 600 Percentage 10.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88361

ISSUE: Cell Enumeration Circulating Tumor Cells

TAB: 25

New Services

Source	CPT	Long Descriptor	Resp	IWPUT	RVW					Total	PRE	INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
Key Reference	88361	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology	39	0.0211			1.18			40				56			
Survey	86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	36	0.0458	0.20	0.77	1.14	1.77	2.80	30		5	15	20	30	60	10
REC	86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required		0.0289			0.69			25				20			5

86153	*Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required*																										
Combined Data (CAP Random Survey and Respondents from Vendor Listing)																											
Response Information				**Survey Intra-Service Time**					**Survey Post-Service Time**					**Survey RVU Recommended**					**Performance Rate**					**86153**		
Code	**#**	**Typical**		**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Rec Intra Time**	**Rec Post Time**	**Rec WRVU**
86153	**36**	**92%**		**5.0**	**15.0**	**20.0**	**30.0**	**60.0**	**2.0**	**5.0**	**10.0**	**12.5**	**30.0**	**0.20**	**0.77**	**1.14**	**1.77**	**2.80**	**2**	**20**	**50**	**125**	**800**	**20.00**	**5.00**	**0.69**
Key Reference Service:			**88361 - Morphometric analysis, tumor immunohistochem (eg, Her-2/neu, estrogen receptor/progesterone receptor), quant or semiquant, each antibody; computer-assisted - 1.18RVU**																						**IWPUT**	**0.0289**
			Avg Intra-Service Complexity/Intensity		Avg Post-Service Complexity/Intensity		Range & Possible dxs options to be considered		Amt &/or Complex Med recs, diag test, or other info to analyze		Urgency of Med Decision-making		Techical Skill - Knowledge, training. & exper necessary to perform scv.		Physical Effort		Risk of significant complications morbid &/or mortality		Outcome depends on skill & judgmnt of MD		Estimated risk of malpractice suit w poor outcome		**Chose Key Ref**	**Key Ref WRVU**	**Key Ref Time-total**	
Urban	**Suburban**	**Rural**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**22.2%**	**1.18**	**40**	
55.6%	**30.6%**	**13.9%**	3.58	3.64	3.58	3.61	3.44	3.58	3.44	3.50	3.64	3.53	3.78	3.86	3.22	3.33	3.28	3.61	3.83	3.81	3.00	3.36				
								New Code - Number of Intensity and Complexity Measures that Exceed Key Reference Service										2	out of	9						
CAP Random Survey of Membership (Survey of 4,974)																											
Response Information				**Survey Intra-Service Time**					**Survey Post-Service Time**					**Survey RVU Recommended**					**Performance Rate**					**86153**		
Code	**#**	**Typical**		**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Rec Intra Time**	**Rec Post Time**	**Rec WRVU**
86153	**15**	**80%**		**15**	**15**	**20**	**30**	**45**	**5**	**5**	**10**	**10**	**30**	**0.25**	**1.10**	**1.10**	**2.00**	**2.23**	**2**	**15**	**20**	**50**	**360**	**20.00**	**5.00**	**0.69**
Key Reference Service:			**88189 - Flow cytometry, interpretation; 16 or more markers - 2.23RVU**																								
			Avg Intra-Service Complexity/Intensity		Avg Post-Service Complexity/Intensity		Range & Possible dxs options to be considered		Amt &/or Complex Med recs, diag test, or other info to analyze		Urgency of Med Decision-making		Techical Skill - Knowledge, training. & exper necessary to perform scv.		Physical Effort		Risk of significant complications morbid &/or mortality		Outcome depends on skill & judgmnt of MD		Estimated risk of malpractice suit w poor outcome		**Chose Key Ref**	**Key Ref WRVU**	**Key Ref Time-total**	
Urban	**Suburban**	**Rural**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**27%**	**2.23**	**50**	
46.7%	**20.0%**	**33.3%**	3.80	3.80	3.80	3.60	3.80	4.00	4.20	3.80	3.80	3.60	4.40	4.20	3.80	3.80	4.40	4.40	4.60	4.40	4.80	4.80				
								New Code - Number of Intensity and Complexity Measures that Exceed Key Reference Service										4	out of	9						
Vendor Listing (Survey of 91)																											
Response Information				**Survey Intra-Service Time**					**Survey Post-Service Time**					**Survey RVU Recommended**					**Performance Rate**					**86153**		
Code	**#**	**Typical**		**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Min**	**25%**	**Median**	**75%**	**Max**	**Rec Intra Time**	**Rec Post Time**	**Rec WRVU**
86153	**21**	**100%**		**5**	**15**	**20**	**29**	**60**	**2**	**5**	**10**	**15**	**30**	**0.20**	**0.69**	**1.18**	**1.45**	**2.36**	**6**	**35**	**100**	**135**	**800**	**20.00**	**5.00**	**0.69**
Key Reference Service:			**88361 - Morphometric analysis, tumor immunohistochem (eg, Her-2/neu, estrogen receptor/progesterone receptor), quant or semiquant, each antibody; computer-assisted - 1.18RVU**																								
			Avg Intra-Service Complexity/Intensity		Avg Post-Service Complexity/Intensity		Range & Possible dxs options to be considered		Amt &/or Complex Med recs, diag test, or other info to analyze		Urgency of Med Decision-making		Techical Skill - Knowledge, training. & exper necessary to perform scv.		Physical Effort		Risk of significant complications morbid &/or mortality		Outcome depends on skill & judgmnt of MD		Estimated risk of malpractice suit w poor outcome		**Chose Key Ref**	**Key Ref WRVU**	**Key Ref Time-total**	
Urban	**Suburban**	**Rural**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**New**	**REF**	**24%**	**1.18**	**40**	
61.9%	**38.1%**	**0.0%**	3.52	3.67	3.52	3.67	3.38	3.62	3.10	3.48	3.76	3.81	3.67	4.00	3.14	3.38	3.14	3.62	3.57	3.81	2.57	3.14				
								New Code - Number of Intensity and Complexity Measures that Exceed Key Reference Service										0	out of	9						

CPT Code:____86153
Specialty Society('s)_____Pathology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required

Global Period:__XXX Meeting Date:__April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further reviewed with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

No other pathology comparison code comes close to the minimum inputs shown here.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

NA -

Service Clinical Labor Activities:

NA - **No direct practice expense inputs in the facility setting**

Post-Service Clinical Labor Activities:

NA -

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required

Global Period:_XXX Meeting Date: _April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP’s expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further reviewed with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: No other pathology comparison code comes close to the minimum inputs shown here.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Service Clinical Labor Activities:

Collate images for Pathologist’s review, print forms, and review discuss images with Pathologist

Post-Service Clinical Labor Activities:

None

	A	B	C	D	E
1	**Cell Enumeration Circulating Tumor Cells - Interpretation and Report**				
2				**86153**	
3	**Meeting Date: April 2012** **Tab: 25** **Specialty: Pathology**	**CMS Code**	**Staff Type**	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	
4	**LOCATION**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity - *specify:*				
18	**End: When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure:**				
21	Greet patient, provide gowning, ensure appropriate medical records are available				
22	Obtain vital signs				
23	Provide pre-service education/obtain consent				
24	Prepare room, equipment, supplies				
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV				
27	Sedate/apply anesthesia				
28	**Intra-service**				
29	Collate Images and Review with Pathologist	L045A	Cytotechnologist	**0**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff				
33	Clean Scope				
34	Clean Surgical Instrument Package				
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
38	Other Clinical Activity - *specify:*				
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**	
42	**End: Patient leaves office**				
43	**POST-SERVICE Period**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes		36		
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	**Total Office Visit Time**			**0.0**	**0.0**
53	Other Clinical Activity - *specify:*				
54	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**Cell Enumeration Circulating Tumor Cells - Interpretation and Report**				
2				**86153**	
3	**Meeting Date: April 2012** **Tab: 25** **Specialty: Pathology**	**CMS Code**	**Staff Type**	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	
4	**LOCATION**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**		
56					
57	**None**				
58					
59					
60					
61					
62	**EQUIPMENT**	**CODE**			
63	CELLSEARCH® System	Invoice	Minutes	**0**	
64	Laboratory Information System	Invoice	Minutes	**0**	
65					
66					

	A	B	C	D	E
1	**Cell Enumeration Circulating Tumor Cells - Interpretation and Report**				
2				**86153**	
3	**Meeting Date: April 2012** **Tab: 25** **Specialty: Pathology**	**CMS Code**	**Staff Type**	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	
4	**LOCATION**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**5.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**5.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity - *specify:*				
18	**End: When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure:**				
21	Greet patient, provide gowning, ensure appropriate medical records are available				
22	Obtain vital signs				
23	Provide pre-service education/obtain consent				
24	Prepare room, equipment, supplies				
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV				
27	Sedate/apply anesthesia				
28	**Intra-service**				
29	Collate Images and Review with Pathologist	L045A	Cytotechnologist	**5**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff				
33	Clean Scope				
34	Clean Surgical Instrument Package				
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
38	Other Clinical Activity - *specify:*				
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**	
42	**End: Patient leaves office**				
43	**POST-SERVICE Period**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes		36		
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	**Total Office Visit Time**			**0.0**	**0.0**
53	Other Clinical Activity - *specify:*				
54	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**Cell Enumeration Circulating Tumor Cells - Interpretation and Report**				
2				**86153**	
3	**Meeting Date: April 2012** **Tab: 25** **Specialty: Pathology**	**CMS Code**	**Staff Type**	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	
4	**LOCATION**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**		
56					
57	**None**				
58					
59					
60					
61					
62	**EQUIPMENT**	**CODE**			
63	CELLSEARCH® System	Invoice	Minutes	**16**	
64	Laboratory Information System	Invoice	Minutes	**4**	
65					
66					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Fourth Five-Year Review
CMS High Expenditure Procedural Codes screen

April 2012

Psychotherapy

In the 4th Five-Year Review of the RBRVS, CMS received comment letters from the providers of psychotherapy, CPT codes 90801-90880 as potentially misvalued. CMS forwarded these services to the RUC to be included in the fourth Five-Year Review process. CPT code 90849 was withdrawn by the original commenter as the specialties indicated that very few of their members provide this service. This specialty recommendation was supported by the Medicare utilization data for this service which was very low in 2008, 343 claims. In April and May 2010, the Research Subcommittee met to review vignettes and reference service lists. The Subcommittee recommended that 90801 and 90802 be removed from the list of codes to be reviewed and be referred to the CPT Editorial Panel so that modifications could be made to the descriptors to reflect the different work performed by the physician and non-physician providers. In June 2010, a RUC Facilitation Committee met with the sponsoring specialty societies. The Pre-Facilitation Committee agreed with the Research Subcommittee's recommendations to refer 90801 and 90802 to the CPT Editorial Panel. The Pre-Facilitation Committee recommended that all of the psychotherapy codes with Evaluation and Management components (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, and 90862) be referred to the CPT Editorial Panel to potentially create a new coding structure based on the varying levels of evaluation and management within each code. The remainder of the CPT codes identified were surveyed for the October 2010 RUC Meeting.

At the October 2010 RUC Meeting, the specialties presented compelling evidence arguments to change the current value of the remaining psychotherapy services. The specialties indicated that the patient population receiving these services has dramatically changed since the codes were previously reviewed. Currently, according to a National Comorbidity Survey, 56% of patients receiving psychotherapy have multiple comorbid conditions, meaning having more than one mental or physical disorder, including substance abuse. Due to the prevalence of comorbid patients, the work of the provider has changed as most research treatment protocols were originally designed for patients with single disorders. Further, the specialties indicated that the site of service for patients receiving many of these services has changed. Patients, who were once treated in the hospital setting, are now more frequently being treated in the office setting as the number of psychiatric beds has dropped by more than 60% between 1970 and 2000. The RUC accepted these compelling evidence arguments to potentially modify the current value of these services.

However, the RUC review of survey data presented at the October 2010 meeting , concluded that the entire section of psychotherapy services would benefit from a restructuring within CPT. A CPT Workgroup was created to address these concerns and a coding proposal was issued from the Workgroup to the CPT Editorial Panel for review. In February 2012, after a year of analysis and participation by all providers of the services, the CPT

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Editorial Panel replaced the current psychotherapy section with a new structure allowing separate reporting of E/M codes, eliminating site of service differential and creation of series of add-on codes to psychotherapy to describe interactive complexity and medication management.

The new coding framework, allows all codes to be used in all settings instead of describing site specific services. There are four groupings of services. First, code 90801 *Psychiatric diagnostic interview examination* will be deleted and replaced by two new codes 90791 *Psychiatric diagnostic evaluation* and 90792 *Psychiatric diagnostic evaluation with medical service*. CPT code 90791 is a service without medical work and describes comprehensive psychiatric diagnostic evaluation of psychological and psychosocial conditions often in collaboration with referring primary care physicians. CPT code 90792 is to be reported when a complete comprehensive diagnostic evaluation involves medical work, capturing the work and teasing out medical causes of psychiatric symptoms such as those caused by thyroid disease or metabolic infectious conditions. The next family has two groupings, psychotherapy stand alone codes without medical services (CPT codes 90832, 90834 and 90837) and the psychotherapy add-on codes, which are used only in conjunction with Evaluation and Management services (90833, 90836 and 90838). The current psychotherapy with E/M inpatient or outpatient codes contain one fixed low level E/M service combined with three levels of time-based psychotherapy services. These fixed E/M components were inadequate for today's patient and are replaced by the psychotherapy add-on codes. Thereby, using the existing E/M structure and a choice of one add-on psychotherapy time-based code, 30, 45 or 60 minutes. The selection of the time increment is based both on patient characteristics and the work to be accomplished in certain types of psychotherapy. Some patients are more resistant to open-up in a session and may require longer sessions. Additionally, some forms of psychotherapy are more geared toward 45 minute sessions (psychodynamic or cognitive behavioral therapy), whereas others are more geared towards 30 minute sessions (brief focused supportive therapy). The add-on codes will be new to many professionals and the American Psychiatric Association will offer extensive education on the use of these codes and to ensure that physicians understand that the time on E/M services is not used to determine the time of the psychotherapy service. The third grouping, psychotherapy inpatient and outpatient services that do not include E/M services (90832, 90834 and 90837) are likely to be reported by psychologists and clinical social workers in all clinical settings. The last grouping are family psychotherapy codes, with and without the patient and in a group setting, remain essentially unchanged (90845, 90846, 90847 and 90853).

90791 Psychiatric diagnostic evaluation

The RUC reviewed the survey results from 202 adult and child psychiatrists, psychologists and social workers for CPT code 90791 and determined that the median work RVU of 3.00 appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service. The RUC compared the surveyed service to key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time) and agreed with the survey respondents that 90791 requires more physician time to perform but is less intense and complex than 99205. The RUC also compared the surveyed service to similar services 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* (work RVU = 3.00 and 60 minutes intra-service time) and 75559 *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging* (work RVU = 2.95 and 50 minutes intra-service time) and

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determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 90791.**

90792 Psychiatric diagnostic evaluation with medical services

The RUC reviewed the survey results from 82 adult and child psychiatrists for CPT code 90792 and determined that the median work RVU of 3.25 appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service. The RUC compared code 90792 to 90791, which does not include medical services, and determined that the survey respondents appropriately valued the additional work required to perform this service. The RUC compared the surveyed service to key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time) and agreed with the survey respondents that 90792 requires more physician time and is more intense and complex to perform than 99205. For additional support, the RUC also compared the surveyed service to similar services 99350 *Home visit for the evaluation and management of an established patient* (work RVU = 3.28 and 75 minutes intra-service time) and 99235 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date* (work RVU = 3.24 and 50 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.25 for CPT code 90792.**

90832 Psychotherapy, 30 minutes with patient and/or family member

The RUC reviewed the survey results from 185 adult and child psychiatrists, psychologists and social workers for CPT code 90832 and determined that the median work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 30 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 96152 *Health and behavior intervention, each 15 minutes, face-to-face; individual* (work RVU = 0.46 and 15 minutes intra-service time) and agreed with the survey respondents that 90832 requires more time and is more intense and complex to perform than 96152. For additional support, the RUC also compared the surveyed service to similar services 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and 94005 *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more* (work RVU = 1.50 and 25 minutes intra-service time) and determined that the recommended work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.50 for CPT code 90832.**

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90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service
The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90833 and determined that the median work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC determined 0 minutes pre-service, 30 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and agreed with the survey respondents that 90833 requires the same physician work, slightly more physician time and similar intensity and complexity to perform compared to 99214. For additional support, the RUC also compared the surveyed service to similar service 94005 *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more* (work RVU = 1.50 and 25 minutes intra-service time) and determined that the recommended work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.50 for CPT code 90833.**

90834 Psychotherapy, 45 minutes with patient and/or family member
The RUC reviewed the survey results from 183 adult and child psychiatrists, psychologists and social workers for CPT code 90834 and determined that the median work RVU of 2.00 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 45 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to similar services 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99 and 30 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.00 for CPT code 90834.**

90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service
The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90836 and determined that the median work RVU of 1.90 appropriately accounts for the physician work required to perform this service. The RUC determined 0 minutes pre-service, 45 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to

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documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and agreed with the survey respondents that 90836 requires more physician work and time and is more intense and complex to perform compared to 99214. For additional support, the RUC also compared the surveyed service to similar service 99221 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 1.92 and 30 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.90 for CPT code 90836.**

90837 Psychotherapy, 60 minutes with patient and/or family member

The RUC reviewed the survey results from 185 adult and child psychiatrists, psychologists and social workers for CPT code 90837 and determined that the survey 75th percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC determined that the survey median work RVU of 2.25 would be too low in relation to 90834 and 0.25 difference in work RVU would not appropriately account for an additional 15 minutes of intra-service time and additional intensity and complexity required to perform 90837. The RUC determined 5 minutes pre-service, 60 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to similar services 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time), 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 60 minutes intra-service time) and 99222 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.61 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 90837.**

90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service

The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90838 and determined that the survey 75th percentile work RVU of 2.50 appropriately accounts for the physician work required to perform this service. The RUC determined that the survey median work RVU of 2.10 would be too low in relation to 90836 and 0.20 difference in work RVU would not appropriately account for an additional 15 minutes of intra-service time and additional intensity and complexity required to perform 90838. The RUC determined 0 minutes pre-service, 60 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99354 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour* (work RVU = 1.77 and 60 minutes intra-service time) and agreed with the

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survey respondents that 90838 requires more physician work and is more intense and complex to perform compared to 99354. For additional support, the RUC also compared the surveyed service to similar service 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 60 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.50 for CPT code 90838.**

90785 Interactive Complexity (List separately in addition to the code for primary procedure)
90839 Psychotherapy for crisis, first 60 minutes;
90840 Psychotherapy for crisis, first 60 minutes; each additional 30 minutes
The specialty societies indicated and the RUC agreed that codes 90785, 90839 and 90840 be carrier priced to allow for education and experience with a significantly different coding structure. This will allow providers to gain experience with the codes prior to conducting a RUC survey. After a year of experience with the new coding structure the specialties will conduct RUC surveys for these services.

90845 Psychoanalysis
October 2011 RUC recommendation
Multiple specialty societies submitted public comment to CMS to review code 90845 *Psychoanalysis* as part of the 4th Five-Year Review. In September 2010, recommendations regarding code 90845 were submitted along with 16 additional codes. During that presentation the specialties requested that the entire tab be referred to the CPT Editorial Panel to revised the code descriptors to more accurately describe these services. During the CPT review process, CPT recommended to remove psychoanalysis, as revisions to the descriptor were unnecessary because the work inherent in providing this service was the same regardless of the provider.

In September 2011, the RUC reviewed 90845 and agreed with the specialty society that there is compelling evidence that the patient population has changed and that the technique employed in psychoanalytic practice has changed. Psychoanalysis traditionally treated a wide variety of conditions which included a considerable number of high functioning patients who were treated for relatively minor psychological problems by current standards. Patients with these conditions are now often treated in a variety of newer treatment modalities rather than psychoanalysis. Given this, patients now receiving psychoanalysis are more complex and typically require a more active approach on part of the psychoanalyst due to the increased number of co-morbidities. In addition, in the past psychoanalysts tended to be silent during the treatment, intervening infrequently. Current practice emphasizes the importance of interaction between the psychoanalyst and the patient. As a result of this technical change the psychoanalyst is required to be much more intently focused on the minute to minute interaction during the session and considerably more active during the session. This substantially increases the psychoanalyst's intensity and complexity effort during the session, when compared with the earlier model.

The RUC reviewed CPT code 90845 and agreed with the specialty societies that the typical service is one hour, 5 minute pre-service, 50 minutes intra-service and 5 minutes immediate post-service time. The RUC reviewed the survey results and agreed that the median survey work RVU of 2.10

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accurately values the typical physician work involved in the procedure. To justify this value, the RUC compared CPT code 90845 to key reference service 99404 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (work RVU = 1.95, total time = 60 minutes). Although the reference code has greater intra service time compared to the surveyed code, the survey respondents indicated and the RUC agreed that intensity and complexity to perform 90845 is greater in every measure compared to reference service 99404. The RUC also compared 90845 to reference code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, total time = 55 minutes). The respondents indicated 90845 was more intense and complex than 99215, specifically the technical skill required to perform 90845 indicated the greatest difference. Finally, the RUC compared 90845 to MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.00, total time = 55 minutes). The RUC determined that these comparison codes coupled with the median survey results support a recommendation of 2.10 work RVUs for CPT code 90845. **The RUC recommends a work RVU of 2.10 for CPT code 90845.**

90846 Family psychotherapy (without the patient present)
The RUC reviewed the survey results from 123 adult and child psychiatrists, psychologists and social workers for CPT code 90846 and determined that the survey median work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and agreed with the survey respondents that 90846 requires more work and time and to perform than 99215. For additional support, the RUC also compared the surveyed service to similar services 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43 and 30 minutes intra-service time) and 99349 *Home visit for the evaluation and management of an established patient* (work RVU = 2.33 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.40 for CPT code 90846.**

90847 Family psychotherapy (conjoint psychotherapy) (with patient present)
The RUC reviewed the survey results from 123 adult and child psychiatrists, psychologists and social workers for CPT code 90847 and determined that the survey median work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 55 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient,* (work RVU = 3.17 and 45 minutes intra-service time) and agreed with the survey respondents that although 90847 requires 10 more minutes of intra-service time, it requires slightly less work to perform than 99205. For additional support, the RUC also compared the surveyed service to similar services 99222 *Initial*

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hospital care, per day, for the evaluation and management of a patient (work RVU = 2.61 and 40 minutes intra-service time) and 99336 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU = 2.46 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.50 for CPT code 90847.**

90853 Group psychotherapy (other than of a multiple-family group)
The RUC reviewed the survey results from 82 adult and child psychiatrists, psychologists and social workers for CPT code 90853 and determined that the current work RVU of 0.59 be maintained. The survey median work RVU of 3.00, for the entire group session divided by 5 the typical number of patients in a group equals 0.60 and maintaining the value appropriately accounts for the work required to perform this service. The RUC agreed with the survey times divided by the typical number of patients resulting in 3 minutes pre-service, 10 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The RUC compared the surveyed service to key reference service 96153 *Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)* (work RVU = 0.10 and 5 minutes total time) and agreed with the survey respondents that 90853 requires more work, time, intensity and complexity to perform than 96153. For additional support, the RUC also compared the surveyed service to MPC code 97002 *Physical therapy re-evaluation* (work RVU = 0.60 and 18 minutes intra-service time) and 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU = 0.63 and 15 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 0.59 for CPT code 90853.**

Practice Expense
The RUC reviewed the direct practice expense inputs submitted by the specialty societies and recommends no modifications.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Psychiatry				
Psychiatry services include diagnostic services, psychotherapy, and other services to an individual, family, or group. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. Services may be provided to a patient in crisis. Services are provided in all settings of care and psychiatry services codes are reported without regard to setting. Services may be provided by a physician or other qualified health care professional. Some psychiatry services may be reported with **Evaluation and Management Services** (99201-99255, 99281-99285, 99304-99337, 99341-99350) or other services when performed. **Evaluation and Management Services** (99201-99285, 99304-99337, 99341-99350) may be reported for treatment of psychiatric conditions, rather than using **Psychiatry Services** codes, when appropriate.				

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Hospital care ~~by the attending physician~~ in treating a psychiatric inpatient or partial hospitalization may be initial or subsequent in nature (see 99221-99233) ~~and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations~~.

Some patients receive hospital evaluation and management services only and others receive hospital evaluation and management services and other procedures. If other procedures such as electroconvulsive therapy or psychotherapy are rendered in addition to hospital evaluation and management services, these ~~should~~may be listed separately (~~ie~~eg, hospital care services (99221-99223, 99231-99233) plus electroconvulsive therapy (90870), or when psychotherapy is done, ~~an~~with appropriate code(s) defining psychotherapy ~~with medical evaluation and management~~ services~~). Modifier 22 may be used to indicate a more extensive service. Modifier 52 may be used to signify a service that is reduced or less extensive than the usual procedure~~.

~~Other evaluation and management services, such as office medical service or other patient encounters, may be described as listed in the section on **Evaluation and Management,** if appropriate.~~

~~The evaluation and management services should not be reported separately, when reporting codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829.~~

Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with the primary physician and other informants such as nurses or family members, and preparation of a report. These ~~consultation~~ services ~~(99241-99255) are limited to initial evaluation and do not involve psychiatric treatment. Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient are~~may be reported using ~~the appropriate codes for established patients, office visits (99211-99215), domiciliary, rest home (99334-99337), or home (99347-99350). If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office~~ consultation codes ~~may be used again. Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem~~see **Consultations**~~) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services~~.

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Interactive Complexity

Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care.

These factors are typically present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Psychiatric procedures may be reported "with interactive complexity" when at least one of the following is present:

1. The need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.

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3. Evidence or disclosure of a sentinel event and mandated report to third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, other physical devices, interpreter or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who:

- Is not fluent in the same language as the physician or other qualified health care professional, or
- Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

When provided in conjunction with the psychotherapy codes 90832-90838, the amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350) and must relate to the psychotherapy service only. Interactive complexity is not a factor for Evaluation and Management Services selection (99201-99255, 99281-99285, 99304-99337, 99341-99350), except as it directly affects key components as defined in Evaluation and Management Services Guidelines (ie, history, examination and medical decision making).

+●90785	LL1	Interactive Complexity (List separately in addition to the code for primary procedure) (Use 90785 is conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853)) (Do not use 90785 in conjunction with 90839, 90840 or in conjunction with E/M services when no psychotherapy service is also reported)	ZZZ	Carrier Price

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Psychiatric Diagnostic ~~or Evaluative Interview~~ Procedures

Psychiatric diagnostic ~~interview examination includes a~~evaluation is an integrated biopsychosocial assessment, including history, mental status, and ~~a disposition, and~~recommendations. The evaluation may include communication with family or other sources~~, ordering~~ and review and ~~medical interpretation~~ordering of ~~laboratory or other medical~~ diagnostic studies~~. In certain circumstances other informants will be seen in lieu of the patient~~.

Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances. Codes 90791, 90792 may be reported once per day and not on the same day as an Evaluation and Management service performed by the same individual for the same patient.

~~Interactive psychiatric diagnostic interview examination is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.~~

The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure. These services should be reported with add-on code 90785 used in conjunction with the diagnostic psychiatric evaluation codes 90791, 90792.

Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day.

D90801		~~Psychiatric diagnostic interview examination~~	XXX	N/A

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D90802		~~Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication~~ (90801 and 90802 have been deleted. To report diagnostic evaluations, see 90791, 90792)	XXX	N/A
●90791	LL2	Psychiatric diagnostic evaluation	XXX	3.00
●90792	LL3	Psychiatric diagnostic evaluation with medical services (Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444) (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)	XXX	3.25

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~~Psychiatric Therapeutic Procedures~~

~~Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy; and Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy.~~
~~Interactive psychotherapy is typically furnished to children. It involves the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.~~

~~Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.~~

~~Some patients receive psychotherapy only and others receive psychotherapy and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (eg, evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.~~

~~In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive using non-verbal techniques versus insight oriented, behavior modifying and/or supportive using verbal techniques), the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy. Face-to-face time when providing psychotherapy with medical evaluation and management services includes time spent providing both psychotherapy and evaluation and management services (ie, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).~~
~~To report medical evaluation and management services furnished on a day when psychotherapy is not provided, select the appropriate code from the **Evaluation and Management Services Guidelines.**~~

~~Office or Other Outpatient Facility~~
~~Insight Oriented, Behavior Modifying~~
~~and/or Supportive Psychotherapy~~

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D90804		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A
D90805		~~with medical evaluation and management services~~	XXX	N/A
D90806		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A
D90807		~~with medical evaluation and management services~~	XXX	N/A
D90808		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90809		~~with medical evaluation and management services~~ (90804, 90805, 90806, 90807, 90808, 90809 have been deleted. To report, see 90832, 90833, 90834, 90836, 90837, 90838 and 99201-99215, 99217-99220, 99224-99226, 99234-99236 as appropriate)	XXX	N/A
D90810		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A

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D90811		~~with medical evaluation and management services~~	XXX	N/A
D90812		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A
D90813		~~with medical evaluation and management services~~	XXX	N/A
D90814		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90815		~~with medical evaluation and management services~~ (90810, 90811, 90812, 90813, 90814, 90815 have been deleted. To report, use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 and 99201-99215, 99217-99220, 99224-99226, 99234-99236 as appropriate)	XXX	N/A
D90816		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A
D90817		~~with medical evaluation and management services~~	XXX	N/A

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D90818		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A
D90819		~~with medical evaluation and management services~~	XXX	N/A
D90821		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90822		~~with medical evaluation and management services~~ (90816, 90817, 90818, 90819, 90821, 90822 have been deleted. To report, see 90832, 90833, 90834, 90836, 90837, 90838 and 99221-99223, 99231-99233, 99304-99316, 99324-99337 as appropriate)	XXX	N/A
D90823		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A
D90824		~~with medical evaluation and management services~~	XXX	N/A
D90826		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A

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D90827		~~with medical evaluation and management services~~	XXX	N/A
D90828		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90829		~~with medical evaluation and management services~~ (90823, 90824, 90826, 90827, 90828, 90829 have been deleted. To report, use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 and 99221-99223, 99231-99233, 99304-99316, 99324-99337 as appropriate)	XXX	N/A

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Psychotherapy

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

The psychotherapy service codes 90832–90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process.

Psychotherapy times are for face-to-face services with patient and/or family member. The patient must be present for all or some of the service. For family psychotherapy without the patient present, use 90846. In reporting, choose the code closest to the actual time (ie, 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. (See instructions for the usage of Time in the Introduction of the CPT code set).

Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to the psychotherapy codes 90832-90838. For psychotherapy for crisis, see "Other Psychotherapy".

Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an Evaluation and Management service (90833, 90836, 90838).

Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with Evaluation and Management services (90833, 90836, and 90838) as add-on codes to the Evaluation and Management service.

Medical symptoms and disorders inform treatment choices of psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows:

1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making.

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2. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (ie, time spent on history, examination and medical decision making **when used for the E/M service** is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported. 3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.				
●90832	LL4	Psychotherapy, 30 minutes with patient and/or family member	XXX	1.50
●+90833	LL5	Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure) (Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)	ZZZ	1.50
●90834	LL6	Psychotherapy, **45** minutes with patient and/or family member	XXX	2.00
●+90836	LL7	Psychotherapy, **45** minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure) (Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350)	ZZZ	1.90
●90837	LL8	Psychotherapy, **60** minutes with patient and/or family member	XXX	3.00

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●+90838	LL9	Psychotherapy, **60** minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure) (Use 90838 in conjunction with 99201-99255, 99304-99337, 99341-99350) (Use the appropriate prolonged services code (99354-99357) for psychotherapy services 68 minutes or longer) (Use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)	ZZZ	2.50

Other Psychotherapy
Psychotherapy for Crisis

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791 or 90792.

Code 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other health care professional is not continuous on that date. Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with 90832 or 90833 (when provided with Evaluation and Management services).

(90840 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes)

●90839	LL10	Psychotherapy for crisis, first 60 minutes;	XXX	Carrier Price

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+●90840	LL11	each additional 30 minutes (List separately in addition to code for primary service) (Use 9080CP2 in conjunction with 9080CP1) (Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)	ZZZ	Carrier Price
90845	LL12	Psychoanalysis	XXX	2.10 (RUC Recommendation October 2011)
90846	LL13	Family psychotherapy (without the patient present)	XXX	2.40
90847	LL14	Family psychotherapy (conjoint psychotherapy) (with patient present)	XXX	2.50
90849		Multiple-family group psychotherapy	XXX	0.59 (No Change)
90853	LL15	Group psychotherapy (other than of a multiple-family group) (Use 90785 in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)	XXX	0.59 (No Change)
D90857		~~Interactive group psychotherapy~~ (90857 has been deleted. To report, use 90785 in conjunction with 90853)	XXX	N/A

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Other Psychiatric Services or Procedures (For repetitive transcranial magnetic stimulation for treatment of clinical depression, see Category III codes 0160T, 0161T) (For analysis/programming of neurostimulators used for vagus nerve stimulation therapy, see 95970, 95974, 95975)				
D90862		~~Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy~~ (90862 has been deleted. To report see evaluation and management codes 99201-99255, 99304-99337, 99341-99350 or 90863)	XXX	N/A
●+90863	LL16	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) (Use 90863 in conjunction with 90832, 90834, 90837) (For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional, who may report Evaluation and Management codes, use the appropriate Evaluation and Management codes 99201-99255, 99281-99285, 99304-99337, 99341-99350 and the appropriate Psychotherapy with Evaluation and Management service 90833, 90836, 90838) (Do not count time spent on providing pharmacologic management services in the time used for selection of the psychotherapy service)	ZZZ	Carrier Price (HCPAC Recommendation)
90875		Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the Patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); ~~approximately 20~~ 30 minutes		
90876		~~approximately~~ 45~~-50~~ minutes		

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April 3, 2012

Barbara Levy, MD, AMA RUC Chair
Sherry L. Smith, MS, CPA, Director, AMA Physician Payment Policy and Systems
American Medical Association
515 North State Street
Chicago, Illinois 60654

Re: Tab 26, Psychotherapy

Dear Dr. Levy and Ms. Smith,

The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), American Psychological Association (APA-HCPAC), and National Association of Social Workers are submitting recommendations on 16* new or revised codes within the Psychiatry section of CPT.

As you know, the above organizations originally put forward 36 codes as part of the fourth Five Year Review process in 2010. These codes comprised the bulk of the codes within the Psychiatry section of CPT. A pre-facilitation committee was assigned early in the process to assist the societies in their efforts. In June 2010 the pre-facilitation committee concurred with the recommendation of the RUC Research Subcommittee that the codes describing the psychiatric diagnostic examinations and psychotherapy with evaluation and management services be referred to the CPT Editorial Panel for review and revision to address changes in work.

Seventeen of the remaining codes were surveyed by the above named organizations, as well as by the American Psychiatric Nurses Association, and recommendations were presented for review by the RUC in October 2010. The RUC accepted the compelling evidence arguments put forward by the specialties as to a change in the work for these codes (see minutes of the October 2010 RUC meeting tab 52 page 87, Attachment 1). The specialties then requested that the 17 psychotherapy services that were to be reviewed at the October 2010 RUC meeting instead be referred to the CPT Editorial Panel for review and possible revision to address differences in work. This request was granted, and these codes were added to the work of a CPT Editorial Panel workgroup that was formed to address the earlier referral for revision of the CPT codes describing the psychiatric diagnostic exams and the codes describing the work when psychotherapy is performed in conjunction with an evaluation and management service.

The CPT Editorial Panel Workgroup on Psychological and Psychiatric Services (PPS), chaired by Patrick Cafferty, PA-C, and Boyd Buser, DO, met over the course of several months to develop a series of CPT codes that would more accurately describe the work performed. During that time, the workgroup determined that the description of work for Psychoanalysis (CPT code 90845) did not require changes and could move forward to the RUC. Recommendations based on the survey data from 2010 were submitted to

*15 codes with 2012 survey data and 1 code, 90845, Psychoanalysis for reaffirmation

the RUC for review at its September 2011 meeting. The RUC accepted the societies' recommended values for 90845, (5 pre-service, 50 intra-service, 5 post-service time; 2.10 RVW) and forwarded that recommendation to CMS. In the 2012 Final Rule, published November XX, 2011, CMS elected not to finalize the RUC's recommended values until the remaining codes in the family were reviewed by the RUC. We are asking that the RUC reaffirm the previously approved values for 90845 at this meeting.

In February 2012, the CPT Editorial Panel approved a revised version of the workgroup's proposal that included 15 new or revised codes. We have submitted RUC recommendations on the following codes:

- 9080D1, Psychiatric diagnostic interview examination
- 9080D2, Psychiatric diagnostic evaluation with medical services
- 908P10 – 908P30 (30, 45, 60 minutes respectively) (XXX code), Psychotherapy with the patient and/or family member
- 908P10X-908P30X (30, 45, 60 minutes respectively) (ZZZ code), Psychotherapy with the patient and/or family member when performed with an evaluation and management service
- 90846, Family Therapy without the patient present
- 90847, Family Therapy with the patient present
- 90853, Group Therapy (other than multiple family group therapy)

As mentioned earlier we are requesting the RUC reaffirm the 2011 recommendation for the following code:

- 90845, Psychoanalysis – Reaffirmation of the RUC's 2011 recommendation

In addition to the recommendations for the codes listed above, we are requesting that the following codes be carrier priced. This will allow for education and experience with a significantly different coding structure than that in place for 2012. This will afford the RUC time to assess options for a survey and it will give providers experience with the codes prior to moving to an AMA RUC survey:

- 9080XE (ZZZ code), Interactive Complexity
- 908CP1, Psychotherapy for Crisis, first 60 minutes
- 908CP2 (ZZZ code), Psychotherapy for crisis, each additional 30 minutes
- 90862X (ZZZ code), Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services

Current RUC Recommendations

The societies sought the approval of the RUC's Research Subcommittee prior to fielding their surveys. The subcommittee granted approval for the following items;

- Modification of the survey tools, including:
    - Adding the term "healthcare professional" to reflect varying educational backgrounds.
    - Adding a link to a PDF of the revised introductory language to the Psychiatry section
    - Modifying the XXX tool (XXX Group) used to survey the group psychotherapy code, 90853, for clarity
        - Adding a question asking for survey participants to indicate the typical number of patients they see in a group session.
        - Asking survey participants to base the time estimates and RVU estimates on the entire session rather than calculating them on a per patient basis.
    - Eliminating the moderate sedation section on the ZZZ tool (ZZZ) used to survey the add-on codes.
- Use of a common Reference Service list for all survey respondents, and approval to include a select number of reference service codes where the RVU calculation was done for the participant per the recommendation made by HCPAC at their September 2011 meeting.

- Approval of a revised vignette for group psychotherapy (the current vignette in the RUC database was found to be typical by only 39% of survey respondents in the last survey process.)
- Modifications to the RUC educational tool, consistent with our requests regarding the healthcare professional and survey changes.
- Approval of a request by the American Psychological Association to conduct both a random survey and a proctored convenience sample of participants attending their March leadership conference.

As a result of the change noted above, the SOR for the group psychotherapy code, 90853, reflects a calculated RVW and times based on responses to the additional questions The survey participants were asked to calculate the RVW and times based on the full length of the session rather than on a per patient basis. Those RVWs were then divided by the typical number of patients in a group therapy session as determined by respondents' answers to that additional survey question and those values were used in completing the SOR.

As we did in the 2011 presentation, we have included a breakdown of the survey results by physicians and non-physicians in those surveys where both groups jointly surveyed to facilitate RUC review of the data.

Thank you for your assistance throughout this process. We look forward to presenting our recommendations at the April RUC meeting in Chicago. We are available before then should you have any questions.

Sincerely,

Jeremy Musher, MD
American Psychiatric Association, RUC Advisor

Sherry Barron Seabrook, MD
American Academy of Child and Adolescent Psychiatry, RUC Advisor

James Georgoulakis, PhD
American Psychological Association, HCPAC Advisor

Doris F. Tomer, LCSW

Doris Tomer, LCSW
National Association of Social Workers, HCPAC Advisor

I. AMA/Specialty RVS Update Committee Meeting Minutes September 29 – October 3, 2010

II. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday, September 30, 2010, at 8:00 am. The following RUC Members were in attendance:

Barbara Levy, MD (Chair)
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Joel Bradley, MD
Ronald Burd, MD
John Gage, MD
William Gee, MD
David Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Robert Kossmann, MD
Walt Larimore, MD
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
Geraldine McGinty, MD
Bill Moran, Jr., MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Peter Smith, MD
Susan Spires, MD
Arthur Traugott, MD
James Waldorf, MD
George Williams, MD
Allan Anderson, MD*
Gregory Barkley, MD*
Dennis M. Beck., MD*
Bruce Deitchman, MD*
Gregory DeMeo, DO*
Jane Dillon, MD*
Verdi DiSesa, MD*
Jeffrey Paul Edelstein, MD*
Emily Hill, PA-C*
Robert Jansen, MD*
M. Douglas Leahy, MD*
William J. Mangold, Jr., MD*
Daniel McQuillen, MD*
Terry Mills, MD*
Scott D. Oates, MD*
Julia Pillsbury, DO*
Chad Rubin, MD*
Steven Schlossberg, MD*
Stanley Stead, MD*
J. Allan Tucker, MD*
Robert Stomel, DO*

*Alternate

III. Chair's Report

- Doctor Levy welcomed the CMS staff and representatives attending the meeting, including:
  - Edith Hambrick, MD, CMS Medical Officer
  - Ken Simon, MD, CMS Medical Officer
  - Ryan Howe
  - Ferhat Kassamali
- Doctor Levy welcomed Jeffrey Cozzens, MD of the CPT Editorial Panel who is observing this meeting.

Gastric Emptying Study (Tab 51)
Kevin Donohoe, MD, SNM; Kenneth McKusick, MD, SNM; Zeke Silva, MD, ACR

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 78264 *Gastric emptying study* as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen.

78264 ***Gastric emptying study***
The specialty society provided compelling evidence there has been a change in technology as the protocol to perform CPT code 78264 has been standardized, the procedure is different than it was 20 years ago and the Harvard methodology was flawed as it used extrapolation to determine physician time and the work RVU. The performance and interpretation of radionuclide solid phase gastric emptying was standardized in 2009. The new guideline standardized the radiolabled meal, the preparation of the patient, the acquisition and processing of the imaging data and the interpretation criteria. The preparation of the patient requires a standard patient questionnaire, assessment of the patient's glucose level, assessment of patient's current medications to avoid an adverse reaction and determining womens' menstrual cycle. The standardized procedure now requires that the interpreting physician be certain that there was or was not >90% gastric emptying of the radiolabeled meal by four hours. Additionally, the interpretation is more complex requiring both greater knowledge of the clinical conditions leading to the procedures as well as the limitations and causes of errors in the results. The RUC determined that there is compelling evidence that the physician work and time required to perform this service has changed.

The RUC review the survey results from 168 radiologists and nuclear medicine physicians for code 78264 and determined that the median work RVU of 0.95 appropriately maintains the relativity among similar services. The RUC compared 78264 to key reference service CPT code 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (work RVU = 0.96 and total time = 22 minutes) and determined that this service is a code comparison because the total physician time is the same, 22 minutes. For further support, the RUC compared this service to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU = 1.00 and total time = 20 minutes) and determined that the total physician time is similar to the surveyed service,.22 and 20 minutes, respectively, and that the survey median work RVU of 0.95 is appropriate in relation to this service. **The RUC recommends a work RVU of 0.95 for CPT code 78264.**

Psychotherapy (Tab 52)
Naakesh Dewan, MD, APA; Chester Schmidt, MD, APA; Sherry Barron-Seabrook, MD, AACAP; Mary Moller, DNP, ARNP, ANA; Eileen Carlson, RN, JD, ANA; James Georgoulakis, PhD, APA; Doris Tomer, LCSW, NASW
Facilitation Committee #1

In the 4th Five-Year Review of the RBRVS, CMS received comment letters from the providers of psychotherapy, CPT codes 90801-90880 as potentially misvalued. CMS forwarded these services to the RUC to be included in the fourth Five-Year Review process. CPT code 90849 was withdrawn by the original commenter as the specialties

indicated that very few of their members provide this service. This specialty recommendation was supported by the Medicare utilization data for this service which was very low in 2008, 343 claims. In April 2010 and May 2010, the Research Subcommittee met to review vignettes and reference service lists. The Subcommittee recommended that 90801 and 90802 be removed from the list of codes to be reviewed and be referred to the CPT Editorial Panel so that modifications could be made to the descriptors to reflect the different work performed by the physician and non-physician providers. In June 2010, the Pre-Facilitation Committee met with the sponsoring specialty societies. The Pre-Facilitation Committee agreed with the Research Subcommittee's recommendations to refer 90801 and 90802 to the CPT Editorial Panel. The Pre-Facilitation Committee recommended that all of the psychotherapy codes with Evaluation and Management components (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, and 90862) be referred to the CPT Editorial Panel to potentially create a new coding structure based on the varying levels of evaluation and management within each code. The remainder of the CPT codes identified were surveyed for the October 2010 RUC Meeting.

At the October 2010 RUC Meeting, the specialties presented compelling evidence arguments to change the current value of the remaining psychotherapy services. The specialties indicated that the patient population receiving these services has dramatically changed since the codes were previously reviewed. Currently, according to a National Comorbidity Survey, 56% of patients receiving psychotherapy have comorbid conditions, meaning having more than one mental or physical disorder, including substance abuse. Due to the prevalence of co-morbid patients, the work of the provider has changed as most research treatment protocols were originally designed for patients with single disorders. Further, the specialties indicated that the site of service for patients receiving many of these services has changed. Patients, who were once treated n the hospital setting, are now more frequently being treated in the office setting at the number of psychiatric beds has dropped by more than 60% between 1970 and 2000. The RUC accepted these compelling evidence arguments to change the current value of these services.

The specialties requested that the remaining psychotherapy codes be referred to the CPT Editorial Panel along with the other psychotherapy codes for revision to address the differences in work performed by the physician and the non-physician providers. The RUC understands that a CPT Workgroup has been created to address all of these concerns with the psychotherapy codes and that a coding proposal will be issued from this Workgroup upon completion of their work to the CPT Editorial Panel for review. **The RUC recommends the psychotherapy codes be referred to the CPT Editorial Panel for revision.**

Nasopharyngoscopy (Tab 53)
Wayne Koch, MD, AAO-HNS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 92511 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

92511 ***Nasopharyngoscopy with endoscope (separate procedure)***
The RUC reviewed the survey results 30 otolaryngologists for CPT code 92511. The RUC noted that there is typically an Evaluation and Management services provided on the same day as this service. The specialties' explained that pre-service time of 11

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90791 Tracking Number LL2 Original Specialty Recommended RVU: **3.00**
Presented Recommended RVU: **3.00**
Global Period: XXX RUC Recommended RVU: **3.00**

CPT Descriptor: Psychiatric diagnostic evaluation code
(Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444)
(Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Diagnostic evaluation of an adult with co-morbid medical conditions who reports increasing anxiety, irritability, and trouble sleeping. Although on antidepressant medication, the patient has been feeling increasingly depressed and helpless and is unable to go to work. The patient was referred by the primary care provider for psychotherapy services.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review reason for referral, usually involves discussion with person who initiated referral, e.g, physician, family, law enforcement, employer, or an initial phone conversation when self-referred. When possible, involves review of records from referral source and lab or consultation reports.

Description of Intra-Service Work: Explain and obtain informed consent, obtain a psychiatric history, including present illness, past history, family history, complete mental status examination; referrals for other tests and evaluations as needed; review and ordering of diagnostic studies; establishing a definitive diagnosis or at least a narrow enough differential to warrant a treatment plan; decision making concerning need for degree of supervision (e.g. hospitalization); counseling with patient concerning diagnosis and options for treatment and proposed options, including explaining the need for and process of psychotherapy. May also include communication with family or other informants in addition to or in lieu of the patient.

Description of Post-Service Work: Arrange for further studies and further care; report to or discussion with referral source; arrange getting additional information; write or dictate results of examination; and frequently involves additional communication with patient and/or family after results of studies are known or additional health care records reviewed. May include report and consultation with third party utilization manager to arrange for payment and funding for proposed treatment.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW					
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers					
CPT Code:	90791					
Sample Size:	1731	**Resp N:**	202	**Response:** 11.6 %		
Description of Sample:	Random and Convenience					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	30.00	**52.00**	126.00	2000.00
Survey RVW:	0.75	2.25	**3.00**	3.20	6.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	50.00	**60.00**	60.00	180.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90791	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.17	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.61	**RUC Time**	7,451,227

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	11,496,707

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99244	XXX	3.02	**RUC Time**

CPT Descriptor Office consultation for a new or established patient, which required these 3 key components: A comprehensive history; a comprehensive examination, and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 86 **% of respondents:** 42.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 90791	Key Reference CPT Code: 99205	Source of Time RUC Time
Median Pre-Service Time	10.00	7.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**90.00**	**67.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.11	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.61
Urgency of medical decision making	3.53	3.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.44	4.51
Physical effort required	2.02	2.15
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.60	3.71
Outcome depends on the skill and judgment of physician	4.23	4.20
Estimated risk of malpractice suit with poor outcome	3.17	3.26

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.21	2.21
Intra-Service intensity/complexity	4.24	4.19

Post-Service intensity/complexity	3.24	3.29

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs)* include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

90791, Psychiatric diagnostic evaluation, is a new code for a service that was previously reported using 90801, Psychiatric diagnostic interview examination. Psychologists and clinical social workers will typically use this code, while physicians and other medical professionals are expected to use 90792, although they may also use 90791 if medical services are not provided. These procedures can be reported in all settings (i.e., outpatient, inpatient, residential care, nursing facility) so the RVW recommended reflects the range of work necessary in order to appropriately provide the service in all settings.

As noted in our cover letter, the RUC accepted the compelling evidence arguments presented by the societies at the RUC's October 2010 meeting.

Survey process
The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to the random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. This in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes that was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The review of the survey data by the expert panel showed that 82 percent of the survey respondents indicated that the vignette described the typical patient. The expert panel concluded the service performance rate was reasonable.

The expert panel supported the median survey time of 15 minutes pre-, 60 minutes intra-, and 20 minutes post-service work. The pre-service work includes locating and reviewing information from multiple sources, including notes from other professionals, correspondence from the patient or family members, symptom check lists, etc.

As noted earlier in the SOR, the intra-service work includes a variety clinical tasks and decision making functions. Given the nature and complexity of the patients and the need to generate comprehensive diagnostic reports, integrate information from multiple sources, follow up with referral sources when necessary, develop formal written treatment plans (typically required by insurers), and arrange appropriate disposition for the patient, and in light of the fact that the provider has no clinical staff to assist with these tasks, the expert panel agrees that 20 minutes accurately reflects the post-service time. **Therefore the expert panel recommends 15 minutes of pre-, 60 minutes intra-, and 20 minutes post-service for a total time of 95 minutes.**

The expert panel reviewed the survey median and 25th percentile data. The panel concluded that the median survey RVW of 3.00 was supported by the key reference service code, 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family* (7, 45, 15; RVW 3.17), which was chosen by 42% of the survey respondents. An analysis of the data on intensity and complexity measures shows that in most instances the survey respondents found the work of the surveyed code was slightly less intense/complex than that of the higher valued reference code. This held true for most of the measures, with the key exceptions being the measure addressing the outcome (dependent on the skill and judgment of the physician) and the intensity and complexity of the intra-service period. Overall, the panel concluded this provided support for the median value.

The expert panel also compared the work of the surveyed code to 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit* (15, 40, 20; RVW 2.61), with a total time of 75 minutes, which has a lower RVW and lower intra and total time, and to 99223, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit* (15, 55, 20; RVW 3.86) with a total time of 90 minutes. The surveyed code fell between the two MPC codes, which both have intra times and total times less than the surveyed code.

In addition, the expert panel compared the work of the surveyed code to 99244, *Office consultation for a new or established patient, which required these 3 key components: A comprehensive history; a comprehensive examination, and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family* (10, 40, 15; RVW 3.02), with a total time of 65 minutes and medical decision making of moderate complexity.

Based on the review and comparisons above, the expert panel believes the median RVW of 3.00 correctly reflects the appropriate rank order of this procedure. They also compared it to the current value of 2.80, and believe that the survey median reflects the appropriate value based on the increased complexity of the patients and the increased intensity of the work as compared to when the current values were established.

Recommendation

In summary, based on comparisons of the reference code, and MPCs, **we recommend a median RVW of 3.00 and median times of 10 minutes pre-, 60 minutes intra-, 20 minutes post-time for a total time of 95 minutes for code 90791.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90801

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry	How often? Rarely
Specialty Psychology	How often? Commonly
Specialty Social Work	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2532026
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on the fact that Medicare accounts for approximately 25% of all physician and clinician payments in the US; and that psychiatrists will only provide this service 1% of the time

Specialty Psychiatry	Frequency 27470	Percentage 1.08 %
Specialty Psychology	Frequency 1796554	Percentage 70.95 %
Specialty Social Work	Frequency 708002	Percentage 27.96 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 753,593 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the most recent RUC database and the assumption that psychiatrists will only provide this service approximately 1% of the time

Specialty Psychiatry	Frequency 7530	Percentage 0.99 %
Specialty Psychology	Frequency 527515	Percentage 69.99 %
Specialty Social Work	Frequency 211006	Percentage 27.99 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90792 Tracking Number LL3 Original Specialty Recommended RVU: **3.25**
Presented Recommended RVU: **3.25**
Global Period: XXX RUC Recommended RVU: **3.25**

CPT Descriptor: Psychiatric diagnostic evaluation with medical services
(Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444)
(Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Diagnostic evaluation of an adult with co-morbid medical conditions who reports worsening depression and agitation. The patient has been feeling hopeless and sleeping poorly, and reports deteriorating work performance and marital problems. The patient was referred by the primary care provider after a six-week trial of an antidepressant medication with little improvement.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review available information including records, reason for referral, outside information and other gathered information such as rating scales and intake data forms including medical review of systems.

Description of Intra-Service Work: Introduce self to patient and obtain informed consent, including discussion of mandatory reporting. The purposes of the evaluation may include assessing competence, assessing safety, establishing a presumptive diagnosis(es) and formulating a treatment plan, including consideration of additional medical evaluation, medication, psychotherapy, or both and the appropriate site of service based on acuity and level of risk for potentially harmful behaviors, among other criteria (in-patient, day treatment or outpatient).

In order to accomplish the above, an extensive history is obtained, including present illness, past psychiatric history, chemical dependency history, family history, social history, and treatments, as well as a medical history, review of systems, and focused questions related to safety, lethality, aggression, and/or competence, as indicated. A specialty specific examination is completed as well. A working therapeutic relationship is established.

The findings are integrated into a diagnostic formulation, including specific medical psychiatric diagnoses, personality considerations, contributing general medical factors, psychosocial stressors and current level of functioning.

Based on these multi-faceted diagnoses, a treatment plan is formulated including consideration of medications, psychotherapy, general medical laboratory or other tests as well as level of care (inpatient, day hospital, intensive outpatient

or outpatient). This plan is discussed with the patient (and other parties as indicated/appropriate), treatment options are reviewed and informed consent is obtained to begin treatment. Prescriptions are provided for medication and additional medical diagnostic tests, when indicated.

Description of Post-Service Work: Arrangements are made for further studies and care including psychotherapy and other scheduled follow-up appointments. Requests may be made for other outside records. Documentation of the visit is completed. Referral sources may be contacted, and records forwarded to them. Follow-up as needed to address questions regarding medications, titration of dosage, and side-effects and results of additional testing. Questions or issues related to the psychiatric reasons for the visit are addressed, including addressing general psychiatric status as well as dealing with subsequent crises.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
CPT Code:	90792				
Sample Size:	1722	**Resp N:**	82	**Response:** 4.7 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	37.50	**100.00**	150.00	1500.00
Survey RVW:	1.00	3.00	**3.25**	3.80	15.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	30.00	50.00	**60.00**	75.00	180.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90792	**Recommended Physician Work RVU: 3.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.17	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	11,496,707

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.61	**RUC Time**	7,451,227

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99244	XXX	3.02	**RUC Time**

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 42.6 **%**

TIME ESTIMATES (Median)	CPT Code: 90792	Key Reference CPT Code: 99205	Source of Time RUC Time
Median Pre-Service Time	10.00	7.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**90.00**	**67.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.49	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.88
Urgency of medical decision making	3.71	3.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.66	4.47
Physical effort required	2.51	2.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.14	4.00
Outcome depends on the skill and judgment of physician	4.54	4.44
Estimated risk of malpractice suit with poor outcome	3.57	3.47

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.40	2.45
Intra-Service intensity/complexity	4.51	4.45

Post-Service intensity/complexity	3.37	3.32

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry).

90792, *Psychiatric diagnostic evaluation with medical services*, is a new code for a physician service that was previously reported by medical and nonmedical professionals using 90801. This new code, *Psychiatric diagnostic interview examination with medical services*, will be used by physicians and other qualified medical professionals. This procedure can be reported in all settings (i.e., outpatient, inpatient, residential care, nursing facility) so the RVW recommended reflects the range of work necessary in order to appropriately provide the service in all settings.

As noted in our cover letter, the RUC accepted the compelling evidence arguments presented by the societies at the RUC's October 2010 meeting.

Survey process
The survey was sent randomly to members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP).

The reference service list was the same list used in all of the other XXX surveys for this family of codes that was reviewed and approved by the RUC Research Subcommittee. This new code 90792 will be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

A typical vignette was developed with assistance of experts from APA and AACAP. It was agreed that while there are a considerable number of children and adolescents evaluated, the typical patient is an adult.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel concluded that 82 survey responses and the service performance rate of 100 per year are reasonable. They noted that while only 71 percent of those responding found the vignette to be typical, the majority of those who indicated the vignette was not typical stated that they worked with children and adolescents so their typical patient was simply not an adult.

The expert panel supported the median survey times of 10 minutes pre, 60 minutes intra, and 20 minutes post. As noted in the work descriptor, the 10 minutes of pre-service time is spent arranging for the appointment and collecting and reviewing medical records and other data, including correspondence from other professionals, the

patient and patient's family , symptom check lists, etc. prior to the first face-to-face visit. The 20 minutes of post-service time is spent scheduling the next appointment, developing a written treatment plan and documenting the visit, following up with others (providers/agencies/family members) to get collateral information and confirm any necessary information, providing verbal or written findings to referring providers, and seeking treatment authorizations. The pre- and post-service times are slightly higher than a higher level E/M office visit for a new patient, but equal to or slightly lower than the higher level initial hospital care code. Based on this comparison, **we recommend 10 minutes pre-, 60 minutes intra-, and 20 minutes post-service time for a total time of 90 minutes.**

We believe the median RVW result of 3.25 appropriately represents the current physician work for this code. This value is supported by an analysis of the intensity and complexity measures comparing the 90792 with the key reference service, 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family,* with an RVW of 3.17 and a total time of 67 minutes (7, 45, 15 pre, intra, and post respectively), which was chosen by 42% of the survey respondents. In reviewing those figures, the survey respondents indicated that the intensity and complexity of the work of the 90792 was greater than the 99205 in every measure with the exception of physical effort and the pre-service time segment, where the differences between the two were 0.02 and 0.05 respectively.

An additional comparison can be made to 99223, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.* (15, 55, 20; RVW of 3.86) for a total time of 90 minutes. In comparing the two services, the expert panel noted that the total time was the same and the variation of the RVW could be accounted for by the increased intensity for inpatient care. They noted that the survey median RVW of 3.25 falls between the codes for the initial day inpatient service and a new patient outpatient visit.

The expert panel also compared the typical work to the inpatient and outpatient consultation codes: 99254, *Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit* (15, 45, 20; RVW 3.29), with a total time of 80 minutes and medical decision making of moderate complexity; and 99244, *Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family*, (10, 40, 15; RVW 3.02) with a total time of 65 minutes and medical decision making of moderate complexity.

The 99254 and the 99244 codes are similar in work and level of medical decision making to the surveyed code and represent work performed in inpatient and outpatient settings. The survey median of 3.25 is greater than the shorter timed service of the 99244 and closer to the 80 minute service of the 99254. For 90792, in addition to completing an evaluation, the physician is also constructing a detailed treatment plan and discussing ongoing treatment options with the patient rather than writing a report back to the referring provider. We believe this comparison supports the median value.

Recommendation

In summary, based on comparisons to the reference code, MPCs, and other codes, **we recommend the median RVW of 3.25, and median times of 10 minutes pre-, 60 minutes intra-, and 20 minutes post-time for a total time of 90 minutes for code 90792.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90801, 90802

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2719532
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on Medicare accounting for approximately 25% of all physician and clinical expenses, and the number of 90801 and 90802s done by psychiatrists in the latest RUC database, and assuming only 1% of them will do an initial evaluation without medical services (908D1).

Specialty Psychiatry Frequency 2719532 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 753,593 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database, with the assumption that 99% of psychiatrists will use this new code for evluation with medical services.

Specialty Psychiatry Frequency 753593 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90832 Tracking Number LL4 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: XXX RUC Recommended RVU: **1.50**

CPT Descriptor: Psychotherapy, 30 minutes with patient and/or family member
(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Psychotherapy for a young adult with the diagnoses of depression, anxiety, and attention deficit disorder who has relationship problems and recently moved away from family. Patient is taking stimulant and antidepressant medications.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers, and family members.

Description of Intra-Service Work: Face-to-face therapeutic communication with patient and/or family member. Obtain objective information and interval history. Examine mental state. Evaluate and explore intensity and complexity of symptoms, feelings, thoughts, and behaviors in the context of psychosocial and health stressors and coping styles. Use a range of psychotherapy approaches to reduce distress, morbidity, and address ongoing behavioral and mental status changes in the patient.

Description of Post-Service Work: Arrange for further services. Coordinate care in writing or by telephone with patient, family, and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
CPT Code:	90832				
Sample Size:	1873	**Resp N:**	185	**Response:** 9.8 %	
Description of Sample:	Random and Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**15.00**	60.00	1600.00
Survey RVW:	0.45	1.00	**1.50**	1.75	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	30.00	**30.00**	30.00	75.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90832	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96152	XXX	0.46	**RUC Time**

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; individual

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.50	**RUC Time**	78,471,610

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99232	XXX	1.39	**RUC Time**	50,265,346

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99382	XXX	1.60	**RUC Time**

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 58 **% of respondents:** 31.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 90832**	**Key Reference CPT Code:** 96152	**Source of Time RUC Time**
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	30.00	15.00	

Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**45.00**	**24.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.09	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.82
Urgency of medical decision making	2.68	2.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.60	3.45
Physical effort required	1.67	1.68
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.54	2.47
Outcome depends on the skill and judgment of physician	3.65	3.40
Estimated risk of malpractice suit with poor outcome	2.47	2.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.11	2.04
Intra-Service intensity/complexity	3.44	3.30
Post-Service intensity/complexity	2.42	2.32

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs)* include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

The 90832, Psychotherapy, 30 minutes with patient and/or family member had previously been reported as 90804 (Psychotherapy 20-30 minutes, outpatient) and 90816 (Psychotherapy, 20-30 minutes, facility). The 90832 will be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

Survey process
The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette. The typical patient for this service is an adult patient.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations involved in this survey convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The review of the survey by the expert panel determined there were 185 survey responses. Sixty-nine percent of the survey respondents found the vignette typical. The panel noted that a variety of reasons were listed by those who did not find the vignette typical. The most frequent response was that they simply did not treat adult patients, some others noted they did not typically see patients for 30 minutes but rather for 45 minutes or that the vignette described a more complex patient than they would see for 30 minutes.

The median survey results regarding time are 10 minutes pre-service, 30 minutes intra-service, and 10 minutes post- service. The expert panel supports the survey results for the median time of 30 minutes for the intra-service. The panel also agreed that the survey result of 10 minutes of pre-service time is representative of what would typically occur with 90832. The panel noted that the post-service times from the survey varied across the three timed psychotherapy codes (90832, 90834, 90837). They believe the post-service time is typically consistent across the three services. They believe that the survey respondents likely underestimated the post-service time for the 90832. The panel believes 12 minutes is typical due to the range of services provided during the post-service period which include arranging for further service, coordinating care with the patient, family, and other professionals such as primary care providers, documenting intra-service and post-service work activities, and providing reports to third-party payers. These activities are typically performed directly by the psychotherapist without assistance of clinical staff. There is also increased documentation time because providers of psychotherapy services typically maintain a separate record from the medical record for psychotherapy process notes as allowed under HIPAA to protect patient privacy. **Therefore, the panel**

recommends 10 minutes pre-service, 30 minutes intra-service, and 12 minutes post-service times for a total of 52 minutes.

An analysis of the intensity and complexity measures of the surveyed code as compared to the key reference service, 96152, *Health and behavior intervention, each 15 minutes, face-to-face; individual* (4, 15, 5; RVW 0.46) shows that the surveyed code is greater in intensity and complexity in nine of the identified areas and the same for the tenth of the eleven measures. The panel agreed that 90832 and 96152 are different services. The skills and expertise required to provide a psychotherapy service exceed those for a health and behavior service. This increased intensity/complexity accounts for a higher RVW of 1.50 for the surveyed code.

Additional support for this is provided by the comparison of the surveyed code to 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family* (5, 25, 10; RVW 1.50), which is similar in work with less total time.

The panel also compared the surveyed code with 99382, *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)* (5, 25, 5; RVW 1.60), with a total time of 35 minutes, which they believe supports the median RVW of 1.50 on the basis of increased time, and increased intensity of work of the surveyed code when compared with a preventive medicine visit with a higher RVW.

The panel further compared the 90833 to 99232, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit* (10, 20, 10; RVW 1.39), with a total time of 40 minutes. The panel believes the median survey value is supported by the increased time of the 90832 and the range of settings in which the service is delivered.

Finally, the expert panel reviewed the median RVW in the context of survey values for the range of timed psychotherapy codes and found that the relativity of the values of the codes across the family of codes was consistent.

Recommendation

In summary, based on the comparisons to the MPCs and other codes, **the expert panel recommends an RVW of 1.50 and median values of 10 minutes pre-, 30 minutes intra-, 12 minutes post-time for a total time of 52 minutes for 90832.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90804, 90816

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry	How often? Sometimes
Specialty Psychology	How often? Commonly
Specialty Social Work	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 8,822,536
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry	Frequency 711249	Percentage 8.06 %
Specialty Psychology	Frequency 5071281	Percentage 57.48 %
Specialty Social Work	Frequency 2759059	Percentage 31.27 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,214,469 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 177157	Percentage 7.99 %
Specialty Psychology	Frequency 1273319	Percentage 57.49 %
Specialty Social Work	Frequency 686485	Percentage 30.99 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90833 Tracking Number LL5 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: ZZZ RUC Recommended RVU: **1.50**

CPT Descriptor: Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service
(List separately in addition to the code for primary procedure)
(Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)
(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Psychotherapy for a young adult with the diagnoses of depression, anxiety, and attention deficit disorder who has relationship problems and recently moved away from family. Patient is taking stimulant and antidepressant medications.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Data from various sources, including past interactions with the patient, current history and mental status findings, information which may have come to light from other historians or outside records, and the patient's behavior, descriptions, and responses to intra-session interventions, are all reviewed or considered and a working therapeutic interpretation, behavioral treatment plan or supportive intervention strategy is formulated and enacted. Examples of the focus of this intervention could include a current acute situation, suicidal thought/ safety plan, or a pattern of dysfunctional behavior. Evidence of behavioral change, demonstration of insight, or reduction in symptoms (anxiety, depression, irritability, etc.) is sought based on the psychotherapeutic interventions.

Description of Post-Service Work: Documentation of the symptoms and behaviors that are the focus of the treatment, as well as the specific psychotherapeutic intervention and work done in the session.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
CPT Code:	90833				
Sample Size:	1797	**Resp N:**	114	**Response:** 6.3 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**100.00**	500.00	9000.00
Survey RVW:	0.48	1.25	**1.50**	1.60	3.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	25.00	**30.00**	35.00	75.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	90833	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**3.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99232	XXX	1.39	**RUC Time**	50,265,346

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99243	XXX	1.88	**RUC Time**	1

CPT Descriptor 2 Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99252	XXX	1.50	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 64 **% of respondents:** 56.1 **%**

TIME ESTIMATES (Median)	CPT Code: 90833	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	3.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**33.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.76	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.83
Urgency of medical decision making	2.79	2.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.43	3.20
Physical effort required	2.02	2.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.79	2.82
Outcome depends on the skill and judgment of physician	3.59	3.55
Estimated risk of malpractice suit with poor outcome	2.93	2.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.81	1.92
Intra-Service intensity/complexity	3.26	3.24

Post-Service intensity/complexity	2.23	2.25

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry).

The 90833, *psychotherapy, 30 minutes with patient and/or family member (list separately in addition to the code for primary service)* had previously been reported as a bundled service (90805, *Psychotherapy 20-30 minutes, office, with medical evaluation and management services; and 90817, Psychotherapy 20-30 minutes, facility, with medical evaluation and management services*) that captured the work of the psychotherapy and the E/M services in one code. The psychotherapy with medical evaluation and management codes varied only by time with the level of E/M work remaining constant. The newly approved framework describes the work more accurately, allowing for the differentiation of the E/M work based on the actual level of service provided. Psychiatrists will select the appropriate evaluation and management code based on the key elements, adding on the psychotherapy add-on code based only on the time spent providing psychotherapy. There is minimal overlap between the E/M service and the psychotherapy procedure. The information collected during the E/M portion of the service informs the psychotherapy process and the time spent collecting that data during the E/M portion is not counted in the time spent providing psychotherapy.

Survey process
The survey for the 90833 was sent to a random sample of psychiatrist members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). This code can be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

The reference service list was the same list used in all of the other ZZZ surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. A typical vignette was developed with assistance of experts from APA and AACAP.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses and the service performance rate. Although there were a number of respondents who indicated they had never performed the service, the expert panel believes these individuals were unfamiliar with the survey process and did not recognize a current service being described in a different way. Of the 114 survey respondents, 70 percent found the vignette to be typical. As with the 9080D2, a significant number of those who said the patient described was not typical indicated that they specialized in child and adolescent or geriatric psychiatry, noting simply that their typical patient was not an adult.

The expert panel supports the median survey times of 30 minutes of intra service time. This code is an add-on code and as such typically has no pre or post time. The expert panel believes that additional documentation requirements for psychotherapy services adds additional time that is not captured in the evaluation and management codes billed with these services. It is typical for payers to require separate documentation of the psychotherapy session including a description of the modality used, the psychotherapeutic intervention, the focus of the session and the patient's response to treatment. The expert panel supports adding an additional 3 minutes post service time to account for that work, particularly in light of the fact that there is no clinical staff to assist in this work. Based on the above, **we recommend 0 minutes pre, 30 minutes intra, and 3 minutes post service time.**

We believe that the median survey RVW of 1.50 appropriately represents the typical work of this service. This is supported by a comparison of the intensity and complexity measures of the surveyed code with the key reference service. 56% of the survey respondents chose 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family, (5, 25, 10; RVW 1.50)* with a total time of 40 minutes, as the key reference service. A comparison of the measures shows that the respondents found the surveyed code to be greater in intensity/complexity to the reference code a majority of the time including during the intra-service period.

In looking at other services, the expert panel compared the 90833 with 99242, *Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.* (5, 25, 10; RVW 1.34). In addition to a slightly longer intra-service time, the expert panel believes that the typical presenting problems addressed in the 90833 are of greater severity than those typically addressed by the low level consultation code, thus supporting a higher RVW.

Additional comparisons were made between the surveyed code and CPT codes 99232, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication.* (10, 20, 10; RVW 1.39) and 99252, *Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.* (5, 25, 10; RVW 1.50). The panel concluded that the intensity of the work of the surveyed code surpassed or equaled the work of these code which have slightly lower intra-service times, thus providing further support for the median RVW.

The expert panel also reviewed the survey data for the entire family of psychotherapy codes and found relativity across the survey results, including the results for 90845, psychoanalysis, which was reviewed by the RUC in September 2011 with reaffirmation requested at this meeting. The panel found that the median RVWs of the 90833, 90836, 90838 codes (psychotherapy when done in conjunction with an E/M service) were equal to or just below that of the 90832, 90834, 90837 codes (psychotherapy only) There is also relativity when compared with other forms of psychotherapy (90845, 90846 and 90847).

Recommendation

In summary, based on comparisons to the reference code, MPC codes, and other codes, **we recommend the median RVW of 1.50, and median times of 0 minutes pre, 30 minutes intra, and 3 minutes post time for a total time of 33 minutes for the 90833.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90805, 90817

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7636948
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry Frequency 6862470 Percentage 89.85 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,439,350 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is the 2010 Medicare Data from the RUC database. We do not anticipate a change.

Specialty Psychiatry Frequency 1295415 Percentage 90.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

Services Reported with Multiple CPT Codes – Psychotherapy when performed with an E/M Service

CPT Code	Global Day	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time
99212	XXX	0.48	2	10	4	16
99213	XXX	0.97	3	15	5	23
99214	XXX	1.5	5	25	10	40
99215	XXX	2.11	5	35	15	55
99224	XXX	0.76	5	10	5	20
99225	XXX	1.39	10	20	10	40
99226	XXX	2	10	30	15	55
99231	XXX	0.76	5	10	5	20
99232	XXX	1.39	10	20	10	40
99233	XXX	2	10	30	15	55
99307	XXX	0.76	5	10	5	20
99308	XXX	1.16	7	15	9	31
99309	XXX	1.55	10	25	10	45
90833	ZZZ	1.5		30	3	33
90836	ZZZ	1.9		45	3	48
90838	ZZZ	2.1		60	3	63

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90834 Tracking Number LL6 Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **2.00**
Global Period: XXX RUC Recommended RVU: **2.00**

CPT Descriptor: Psychotherapy, 45 minutes with patient and/or family member
(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Psychotherapy for an adult suffering from co-morbid medical conditions, depression, and agitation of two months duration which resulted in loss of job after several emotional outbursts at work. Patient is anxious about loss of income and inability to find another job.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers, and family members.

Description of Intra-Service Work: Face-to-face therapeutic communication with patient and/or family member. Obtain objective information and interval history. Examine mental state. Evaluate and explore intensity and complexity of symptoms, feelings, thoughts, and behaviors in the context of psychosocial and health stressors and coping styles. Use a range of psychotherapy approaches to reduce distress, morbidity, and address ongoing behavioral and mental status changes in the patient.

Description of Post-Service Work: Arrange for further services. Coordinate care in writing or by telephone with patient, family, and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
CPT Code:	90834				
Sample Size:	1873	**Resp N:**	183	**Response:** 9.7 %	
Description of Sample:	Random and Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	30.00	**240.00**	700.00	2500.00
Survey RVW:	0.98	1.50	**2.00**	2.35	4.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	45.00	**45.00**	45.00	95.00

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90834	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96152	XXX	0.46	**RUC Time**

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; individual

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,650,554

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.11	**RUC Time**	9,976,351

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 52 **% of respondents:** 28.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 90834**	**Key Reference CPT Code:** 96152	**Source of Time RUC Time**
Median Pre-Service Time	5.00	4.00	

Median Intra-Service Time	45.00	15.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**60.00**	**0.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.25
Urgency of medical decision making	3.21	3.04
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.04	3.75
Physical effort required	1.77	1.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.08	3.02
Outcome depends on the skill and judgment of physician	3.98	3.76
Estimated risk of malpractice suit with poor outcome	2.82	2.73

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.24	2.25
Intra-Service intensity/complexity	3.90	3.71
Post-Service intensity/complexity	2.84	2.79

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs)* include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

The 90834, Psychotherapy, 45 minutes with patient and/or family member had previously been reported as 90806 (Psychotherapy 45-50 minutes, outpatient) and 90816 (Psychotherapy, 45-50 minutes, facility). The 90834 will be used in all settings (i.e., outpatient, inpatient, residential, nursing facility).

Survey process

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC.

The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette. The typical patient for this service is an adult patient.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the survey results citing that 82 percent of the 183 survey respondents found the vignette typical and the median service performance rate was 240, which is a reasonable number for this service.

The survey results regarding time are 10 minutes pre-service, 45 minutes intra-service, and 12 minutes post-service. The panel supported the survey results for the median time of 45 minutes for the intra-service. As with the 90832, there is typically increased documentation time as a result of maintaining a separate record from the medical record for psychotherapy process notes as allowed under HIPAA to protect patient privacy.

Support for the median RVW of 2.00 can be found in the comparison of the surveyed code with the key reference service. Twenty-eight percent of the survey respondents chose 96152, *Health and behavior intervention, each 15 minutes, face-to-face; individual,* as the key reference service. An analysis of the intensity and complexity measures shows that the respondents rated the surveyed code higher in every measure except two (physical effort and the pre-service time segment). The increased intensity and complexity in addition to the total time of the service supports the median value.

In addition, the panel compared the surveyed code to 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* (5, 35, 15; RVW 2.11) with a total time of 55 minutes. The panel believes that increased time of the 90834 more than accounts for any variation in the intensity of the two services. The value is further supported by the fact that the surveyed code can be used in any setting (outpatient, inpatient, residential care, nursing facility) and the intensity of the patient encounter can vary greatly within each setting.

Additional support comes from the comparison of the surveyed code to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit* (10, 30, 15; RVW 2.00) which has a similar time and RVW. The panel believes the increased time of 90834 more than accounts for any variation in the RVW of the two services. The value is further supported by the fact that the surveyed code can be used in any setting (inpatient, outpatient, residential care, nursing facility) where the intensity of the patient encounter can vary greatly.

Finally, the expert panel also compared the median survey results of the 90834 to the other median survey results and found that the median value maintains relativity within the family. Psychoanalysis, which has a slightly longer intra-service time, is valued at 2.10 based on the RUC's review of that code at the September 2011 RUC meeting. The expert panel believes the work of the two services is similar and thus supportive of the median RVW. The 90834 also maintains relativity with the other timed-psychotherapy codes.

Recommendations
In summary, based on the comparisons to the key reference service and MPC codes **we recommend the median RVW of 2.00 with 10 minutes pre-, 45 minutes intra-, and 12 minutes post-time for a total time of 67 minutes for 90834.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90806, 90818

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry	How often? Sometimes
Specialty Psychology	How often? Commonly
Specialty Social Work	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 30873016
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry	Frequency 1887479	Percentage 6.11 %
Specialty Psychology	Frequency 15058230	Percentage 48.77 %
Specialty Social Work	Frequency 13143397	Percentage 42.57 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,736,176 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 472680	Percentage 6.10 %
Specialty Psychology	Frequency 3790726	Percentage 48.99 %
Specialty Social Work	Frequency 3293290	Percentage 42.56 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90836 Tracking Number LL7 Original Specialty Recommended RVU: **1.90**
Presented Recommended RVU: **1.90**
Global Period: ZZZ RUC Recommended RVU: **1.90**

CPT Descriptor: Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service
(List separately in addition to the code for primary procedure)
(Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350)
(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Psychotherapy for an adult suffering from co-morbid medical conditions, depression, and agitation of two months duration which resulted in loss of job after several emotional outbursts at work. Patient is anxious about loss of income and inability to find another job.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Data from various sources, including past interactions with the patient, current history and mental status findings, information which may have come to light from other historians or outside records, and the patient's behavior, descriptions, and responses to intra-session interventions, are all reviewed or considered and a working therapeutic interpretation, behavioral treatment plan or supportive intervention strategy is formulated and enacted. Examples of the focus of this intervention could include a current acute situation, suicidal thought/ safety plan, or a pattern of dysfunctional behavior. Evidence of behavioral change, demonstration of insight, or reduction in symptoms (anxiety, depression, irritability, etc.) is sought based on the psychotherapeutic interventions.

Description of Post-Service Work: Documentation of the symptoms and behaviors that are the focus of the treatment, as well as the specific psychotherapeutic intervention and work done in the session.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD		
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry		
CPT Code:	90836		
Sample Size:	1797	**Resp N:** 114	**Response:** 6.3 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**75.00**	200.00	1000.00
Survey RVW:	0.65	1.70	**1.90**	2.00	4.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	40.00	**45.00**	50.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	90836	**Recommended Physician Work RVU: 1.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**3.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service?

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,650,554

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99243	XXX	1.88	**RUC Time**	1

CPT Descriptor 2 Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99221	XXX	1.92	**RUC Time**

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 30.7 **%**

TIME ESTIMATES (Median)	CPT Code: 90836	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	45.00	25.00	
Median Immediate Post-service Time	3.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**48.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.31	3.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.19
Urgency of medical decision making	3.31	3.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.59	3.47
Physical effort required	2.34	2.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.19	3.09
Outcome depends on the skill and judgment of physician	3.66	3.53
Estimated risk of malpractice suit with poor outcome	3.13	3.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.32	2.27

Intra-Service intensity/complexity	3.55	3.45
Post-Service intensity/complexity	2.97	2.97

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry).

The 90836, *psychotherapy, 45 minutes with patient and/or family member (list separately in addition to the code for primary service)* had previously been reported as a bundled service (90807, *Psychotherapy 45-50 minutes, office, with medical evaluation and management services; and 90819, Psychotherapy 45-50 minutes, facility, with medical evaluation and management services*) that captured the work of the psychotherapy and the E/M services in one code. The psychotherapy with medical evaluation and management codes varied only by time with the level of E/M work remaining constant. The newly approved framework describes the work more accurately, allowing for the differentiation of the E/M work based on the actual level of service provided. Psychiatrists will select the appropriate evaluation and management code based on the key elements, adding on the psychotherapy add-on code based only on the time spent providing psychotherapy. There is minimal overlap between the E/M service and the psychotherapy procedure. The information collected during the E/M portion of the service informs the psychotherapy process and the time spent collecting that data during the E/M portion is not counted in the time spent providing psychotherapy.

Survey process
The survey for the 90836 was sent to a random sample of psychiatrist members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). This code can be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility). The reference service list was the same list used in all of the other ZZZ surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. A typical vignette was developed with assistance of experts from APA and AACAP.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses and the service performance rate. As with the 90833, there were a number of respondents who indicated they had never performed the service. The expert panel believes these individuals were unfamiliar with the survey process and did not recognize a current service being described in a different way. Of the 114 survey respondents, 75 percent found the vignette to be typical. Those that did not find the vignette typical were primarily individuals who specialized in child and adolescent or geriatric psychiatry.

The expert panel supports the median survey times of 45 minutes of intra-service time. As with the 90833, the expert panel believes that additional post-service documentation requirements for psychotherapy services due to payer requirements adds additional time that is not captured in the evaluation and management codes billed with these services, particularly in light of not employing clinical staff. The expert panel supports adding an additional 3 minutes post-service time to the 90836 to account for that work. Based on the above, **we recommend 0 minutes pre-, 45 minutes intra-, and 3 minutes post- service time.**

The expert panel believes that the median survey RVW of 1.90 appropriately represents the typical work of this service. This is supported by a comparison of the intensity and complexity measures of the surveyed code with the key reference service. Thirty percent of the survey respondents chose 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family, (5, 25, 10; RVW 1.50)* as the reference service. The expert panel reviewed the intensity and complexity measures and found that the respondents rated the surveyed code higher in every category with the exception of the post-service period, which was rated equally. The expert panel concurred that the higher measures of intensity and complexity coupled with the significantly longer intra-service time of the surveyed code supported the median value of 1.90 which is less than the current value for the codes this add-on replaces, 90807 (0,50,0; RVW 2.02) and 90819 (0, 45, 0; RVW 2.05)

In comparing the surveyed code with 99221*, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.* (10, 30, 10; RVW 1.92), the expert panel reported that the typical work of a 45 minute psychotherapy session is similar to that of the lowest level initial hospital care code.

The expert panel compared the 90836 to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.*(10, 30, 15; RVW 2.0) and believes that the work in the surveyed code is similar given the increased service time of the surveyed code in comparison with the typical time of the 99233 code.

The expert panel also concluded that the 99243, *Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* (5, 28, 7; RVW 1.88) was similar in work and the differences in RVWs could be accounted for due to the longer intra-service time of the surveyed code.

The expert panel also reviewed the survey data for the entire family of psychotherapy codes and found relativity across the survey results, including the results for 90845, psychoanalysis, which was reviewed by the RUC in September 2011 with reaffirmation requested at this meeting. The panel found that the median RVWs of the 90833, 90836, 90838 codes (psychotherapy when done in conjunction with an E/M service) were equal to or just below that of the 90832, 90834, 90837 codes (psychotherapy only) There is also relativity when compared with other forms of psychotherapy (90845, 90846 and 90847).

Recommendation:

In summary, based on comparisons to the reference code, MPC codes, and other codes, **we recommend the**

median RVW of 1.90, and median times of 0 minutes pre, 45 minutes intra, and 3 minutes post time for a total time of 48 minutes for 90836.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90807, 90819

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4231608
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry Frequency 3785326 Percentage 89.45 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 795,328 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on latest RUC database.

Specialty Psychiatry Frequency 715795 Percentage 89.99 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

Services Reported with Multiple CPT Codes – Psychotherapy when performed with an E/M Service

CPT Code	Global Day	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time
99212	XXX	0.48	2	10	4	16
99213	XXX	0.97	3	15	5	23
99214	XXX	1.5	5	25	10	40
99215	XXX	2.11	5	35	15	55
99224	XXX	0.76	5	10	5	20
99225	XXX	1.39	10	20	10	40
99226	XXX	2	10	30	15	55
99231	XXX	0.76	5	10	5	20
99232	XXX	1.39	10	20	10	40
99233	XXX	2	10	30	15	55
99307	XXX	0.76	5	10	5	20
99308	XXX	1.16	7	15	9	31
99309	XXX	1.55	10	25	10	45
90833	ZZZ	1.5		30	3	33
90836	ZZZ	1.9		45	3	48
90838	ZZZ	2.1		60	3	63

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90837 Tracking Number LL8 Original Specialty Recommended RVU: **2.25**
Presented Recommended RVU: **2.25**
Global Period: XXX RUC Recommended RVU: **3.00**

CPT Descriptor: Psychotherapy, 60 minutes with patient and/or family member
(Use the 90785in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Psychotherapy for adult with anxiety and depressive symptoms who is on several medications for two co-morbid medical conditions. Patient has returned to work after a recent psychiatric hospitalization for depression. Psychosocial stressors at work and home have increased anxiety and depression since discharge.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers, and family members.

Description of Intra-Service Work: Face-to-face therapeutic communication with patient and/or family member. Obtain objective information and interval history. Examine mental state. Evaluate and explore intensity and complexity of symptoms, feelings, thoughts, and behaviors in the context of psychosocial and health stressors and coping styles. Use a range of psychotherapy approaches to reduce distress, morbidity, and address ongoing behavioral and mental status changes in the patient.

Description of Post-Service Work: Arrange for further services. Coordinate care in writing or by telephone with patient, family, and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW					
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers					
CPT Code:	90837					
Sample Size:	1873	**Resp N:**	185	**Response:** 9.8 %		
Description of Sample:	Random and Conveinence					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**100.00**	300.00	1500.00
Survey RVW:	0.98	1.95	**2.25**	3.00	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	55.00	**60.00**	60.00	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90837	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96152	XXX	0.46	**RUC Time**

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; individual

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.11	**RUC Time**	9,976,351

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.61	**RUC Time**	7,451,227

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99204	XXX	2.43	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 62 **% of respondents:** 33.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 90837**	**Key Reference CPT Code:** 96152	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	4.00	

Median Intra-Service Time	60.00	15.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**75.00**	**24.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.48
Urgency of medical decision making	3.53	3.28
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.27	4.02
Physical effort required	1.93	1.98
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.52	3.26
Outcome depends on the skill and judgment of physician	4.17	3.91
Estimated risk of malpractice suit with poor outcome	3.09	3.02

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.53	2.40
Intra-Service intensity/complexity	4.28	3.91
Post-Service intensity/complexity	3.10	2.98

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs)* include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

The 90837, Psychotherapy, 60 minutes with patient and/or family member had previously been reported as 90808 (Psychotherapy 75-80 minutes, outpatient) and 90819 (Psychotherapy, 75-80 minutes, facility). The 90837 will be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

Survey process
The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the survey results citing that 81 percent of the 185 survey respondents found the vignette typical and the median service performance rate was 100, which is a reasonable number for this service.

The survey results regarding time are 10 minutes pre-service, 60 minutes intra-service, and 15 minutes post-service. Support for the median RVW of 2.25 can be found in the comparison of the surveyed code with the key reference service. Thirty-three percent of the survey respondents chose 96152, *Health and behavior intervention, each 15 minutes, face-to-face; individual,* as the key reference service. An analysis of the intensity and complexity measures shows that the respondents rated the surveyed code higher in every measure except one - physical effort. The panel believes the increased intensity and complexity in addition to the total time of the service supports the median value.

In addition, the panel compared the surveyed code to 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.*(5, 35, 15; RVW 2.11) with a total time of 55 minutes. The panel believes that substantially increased time of the 90837 more than accounts for any variation in the

intensity of the two services. The value is further supported by the fact that the surveyed code can be used in any setting (outpatient, inpatient, residential care, nursing facility) where the intensity of the patient encounter can vary greatly.

Additional support comes from the comparison of the surveyed code to 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit* (15, 40, 20; RVW 2.61) which has a time that is similar to the surveyed code and with the larger RVW of the 99222 accounting for any increased intensity.

Finally, the expert panel also compared the median survey results of the 90837 to the other median survey results and found that the median maintains relativity of values within the family of psychotherapy codes.

Recommendations
In summary, based on the comparisons to the key reference service and MPC codes **we recommend an RVW of 3.00 with 5 pre-, 60 intra-, and 10 post-service minutes for a total time of 82 minutes for 90837.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90808, 90821

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Sometimes

Specialty Psychology How often? Sometimes

Specialty Social Work How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1681744

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry	Frequency 89083	Percentage 5.29 %
Specialty Psychology	Frequency 631443	Percentage 37.54 %
Specialty Social Work	Frequency 886103	Percentage 52.68 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 421,766 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most current RUC database.

Specialty Psychiatry	Frequency 22271	Percentage 5.28 %
Specialty Psychology	Frequency 157861	Percentage 37.42 %
Specialty Social Work	Frequency 221526	Percentage 52.52 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90838 Tracking Number LL9 Original Specialty Recommended RVU: **2.10**
Presented Recommended RVU: **2.10**
Global Period: ZZZ RUC Recommended RVU: **2.50**

CPT Descriptor: Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service
(List separately in addition to the code for primary procedure)
(Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)
(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)
(Use the appropriate prolonged services code (99354-99357) for psychotherapy services 68 minutes or longer)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Psychotherapy for adult with anxiety and depressive symptoms who is on several medications for these conditions and two co-morbid medical conditions. Patient has returned to work after a recent psychiatric hospitalization for depression. Psychosocial stressors at work and home have increased anxiety and depression since discharge.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Data from various sources, including past interactions with the patient, current history and mental status findings, information which may have come to light from other historians or outside records, and the patient's behavior, descriptions, and responses to intra-session interventions, are all reviewed or considered and a working therapeutic interpretation, behavioral treatment plan or supportive intervention strategy is formulated and enacted. Examples of the focus of this intervention could include a current acute situation, suicidal thought/ safety plan, or a pattern of dysfunctional behavior. Evidence of behavioral change, demonstration of insight, or reduction in symptoms (anxiety, depression, irritability, etc.) is sought based on the psychotherapeutic interventions.

Description of Post-Service Work: Documentation of the symptoms and behaviors that are the focus of the treatment, as well as the specific psychotherapeutic intervention and work done in the session.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
CPT Code:	90838				
Sample Size:	1797	**Resp N:**	114	**Response:** 6.3 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**30.00**	100.00	3000.00
Survey RVW:	0.65	1.92	**2.10**	2.50	5.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	55.00	**60.00**	70.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	90838	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**3.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99354	ZZZ	1.77	**RUC Time**

CPT Descriptor Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99387	XXX	2.50	**RUC Time**	0

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,650,554

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99221	XXX	1.92	**RUC Time**

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 30.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 90838**	**Key Reference CPT Code:** 99354	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	

Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	3.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**63.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.03	4.03
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	4.24
Urgency of medical decision making	3.97	3.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.48	4.45
Physical effort required	2.83	2.59
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.03	3.87
Outcome depends on the skill and judgment of physician	4.39	4.42
Estimated risk of malpractice suit with poor outcome	3.87	3.84

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.64	2.58
Intra-Service intensity/complexity	4.55	4.55
Post-Service intensity/complexity	3.42	3.42

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The 90838, *psychotherapy, 60 minutes with patient and/or family member (list separately in addition to the code for primary service)* had previously been reported as a bundled service (90809, *Psychotherapy 75-80 minutes, office, with medical evaluation and management services;* and 90822, *Psychotherapy 75-80 minutes, facility, with medical evaluation and management services*) that captured the work of the psychotherapy and the E/M services in one code. The psychotherapy with medical evaluation and management codes varied only by time with the level of E/M work remaining constant. The newly approved framework describes the work more accurately, allowing for the differentiation of the E/M work based on the actual level of service provided. Psychiatrists will select the appropriate evaluation and management code based on the key elements, adding on the psychotherapy add-on code based only on the time spent providing psychotherapy. There is minimal overlap between the E/M service and the psychotherapy procedure. The information collected during the E/M portion of the service informs the psychotherapy process and the time spent collecting that data during the E/M portion is not counted in the time spent providing psychotherapy.

Survey process

The survey for the 90838 was sent to a random sample of psychiatrist members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). This code can be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility). The reference service list was the same list used in all of the other ZZZ surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. A typical vignette was developed with assistance of experts from APA and AACAP.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses and the service performance rate. It was the opinion of the expert panel that this has not generally been a high volume service. As with the 90833 and the 90836, there were a number of respondents who indicated they had never performed the service however the expert panel believes these individuals were unfamiliar with the survey process and did not recognize a current service being described in a different way. Of the 114 survey respondents, 74 percent found the vignette to be typical. Many of those that did not find the patient typical were primarily individuals who specialized in child and adolescent or geriatric psychiatry who simply said their typical patient was not an adult.

The expert panel supports the median survey time of 60 minutes of intra service time. As with the 90833 and 90836, the expert panel believes that additional post-service documentation requirements for psychotherapy services due to payer requirements adds additional time that is not captured in the evaluation and management codes billed with these services, particularly in light of not employing clinical staff. The expert panel supports adding an additional 3 minutes post-service time to the 90838 to account for that work. Based on the above, **we recommend 0 minutes pre, 60 minutes intra, and 3 minutes post service time.**

Thirty percent of the survey respondents chose 99354, *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or*

other outpatient Evaluation and Management service) (0, 60, 0; RVW 1.77), as the key reference service. A review of the intensity and complexity measures shows that the respondents rated the surveyed code the same or higher in a majority of the areas. The expert panel believes that this increased work substantiates the higher median RVW of 2.10 proposed by the survey respondents.

The expert panel compared 90838 to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit* (10, 30, 15; RVW 2.0), which was the second highest code chosen for comparison by the survey respondents. The panel believed this code supported the median value of the surveyed code, which is substantially longer in intra-service time than this reference code.

An additional comparison of 90838 to 99387, *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older* (4, 45, 10; RVW 2.5), supports the median value of 2.10 of the surveyed code which has longer intra-service time and is focused on an existing illness and specific psychotherapeutic interventions.

And the expert panel believed that 99404, *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (0, 60, 0; RVW 1.95) provided another strong comparison.

The expert panel also compared 90838 to 90845, psychoanalysis, which has a slightly shorter intra-service time and a RUC recommended RVW of 2.10 based on the RUC's review of that code at its September 2011 meeting. The expert panel believes the work of the two services is similar and thus supportive of the median RVW.

As with the 90836, the median survey RVW of 2.10 is substantially less than the current values of the psychotherapy with E/M service codes this code is replacing, 90809 (0, 80, 0; RVW 2.95) and 90822 (0, 78, 0; RVW 2.99).

The expert panel also reviewed the survey data for the entire family of psychotherapy codes and found relativity across the survey results, including the results for 90845, psychoanalysis, which was reviewed by the RUC in September 2011 with reaffirmation requested at this meeting. The panel found that the median RVWs of the 90833, 90836, 90838 codes (psychotherapy when done in conjunction with an E/M service) were equal to or just below that of the 90832, 90834, 90837 codes (psychotherapy only) There is also relativity when compared with other forms of psychotherapy (90845, 90846 and 90847).

Recommendation
In summary, based on comparisons to the reference code, MPC codes, and other codes, **we recommend an RVW of 2.50 , and median times of 60 intra, and 3 post for a total time of 63 minutes for 90838.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90809, 90822

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 164976
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total payments for physician and clinical services in US

Specialty Psychiatry Frequency 139921 Percentage 84.81 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 31,122 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database.

Specialty Psychiatry Frequency 26453 Percentage 84.99 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

Services Reported with Multiple CPT Codes – Psychotherapy when performed with an E/M Service

CPT Code	Global Day	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time
99212	XXX	0.48	2	10	4	16
99213	XXX	0.97	3	15	5	23
99214	XXX	1.5	5	25	10	40
99215	XXX	2.11	5	35	15	55
99224	XXX	0.76	5	10	5	20
99225	XXX	1.39	10	20	10	40
99226	XXX	2	10	30	15	55
99231	XXX	0.76	5	10	5	20
99232	XXX	1.39	10	20	10	40
99233	XXX	2	10	30	15	55
99307	XXX	0.76	5	10	5	20
99308	XXX	1.16	7	15	9	31
99309	XXX	1.55	10	25	10	45
90833	ZZZ	1.5		30	3	33
90836	ZZZ	1.9		45	3	48
90838	ZZZ	2.1		60	3	63

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:90845 Tracking Number Specialty Society Recommended RVU: **2.10**
Global Period: XXX RUC Recommended RVU: **2.10**

CPT Descriptor: Psychoanalysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old man with dysthymia and narcissistic personality disorder manifested by entitlement, inability to be intimate, and extreme variability of self esteem is seen in the second year of psychoanalysis, just prior to going on a business trip. Argumentative and easily offended, he accuses the analyst of being insensitive and detached, and angrily rejects any effort to explore the basis of his mood or behavior.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work: Preparing to see patient; refreshing memory about recent sessions; assessing and managing one's own psychological reactions to the patient.

Description of Intra-Service Work: In person therapeutic communication with patient; implicitly obtaining information and observing the patient's mental state; evaluating and exploring the intensity of symptoms, feelings, thoughts, conflicts, fantasies, behaviors, and dreams as necessary; exploring the patient's and one's own feelings, fantasies and thoughts about the evolving therapeutic relationship as a model for gaining perspective on significant difficulties in the patient's other relationships (transference and countertransference); introducing the impact of the patient's engagement on the analyst as a data source for grasping the patient's effects on other relationships; providing psychological interpretations regarding defenses, conflicts and tendencies in patient's personality and relationships, including awareness of mental process, self-esteem, self-regulation, and impulse control; addressing impediments to ongoing behavioral change that could reduce distress and promote well-being.

Description of Post-Service Work: Documenting the services provided intra-service including reviewing content and process of session, reflection on the psychoanalyst's reactions to the patient's affects, communications and behavior in the session and identifying issues requiring follow-up at next/future sessions; related consultation with peers and review of literature pertinent to the case.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jeremy Musher, MD; James Georgoulakis, PhD; Doris Tomer, LCSW		
Specialty(s):	American Psychiatric Association, American Psychological Association, National Association of Social Workers		
CPT Code:	90845		
Sample Size:	1321	**Resp N:** 55	**Response:** 4.1 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th %	Median*	75th %	High
Service Performance Rate	0.00	0.00	**125.00**	450.00	1600.00
Survey RVW:	0.10	1.86	**2.10**	2.70	200.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	45.00	**50.00**	60.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90845	**Recommended Physician Work RVU: 2.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99404	XXX	1.95	**RUC Time**

CPT Descriptor

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.11	**RUC Time**	10,112,992

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,952,122

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit

Other Reference CPT Code	Global	Work RVU	Time Source
99387	XXX	2.06	**RUC Time**

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 32.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 90845**	**Key Reference CPT Code:** 99404	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	50.00	60.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**60.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.17	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.67
Urgency of medical decision making	3.61	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.56	3.67
Physical effort required	2.28	2.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.61	3.44
Outcome depends on the skill and judgment of physician	4.67	3.83
Estimated risk of malpractice suit with poor outcome	3.50	3.39

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.11
Intra-Service intensity/complexity	4.44	3.89
Post-Service intensity/complexity	3.33	3.11

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

Psychoanalysis, CPT code 90845, was put forward along with a majority of the codes within the psychiatry section of CPT as part of the fourth Five-Year Review process. As noted in the attached letter from the specialty societies, we believe there has been a change in the work required in this service. Our letter to CMS highlights the changes in the patient population with references substantiating the increased complexity of the patients. We have also provided additional information under the section on compelling evidence for changes in technique since this code was last reviewed by the RUC in 1995.

Recommendations regarding this code were originally submitted for the September 2010 RUC meeting along with 16 additional codes that were identified as being misvalued. During that presentation the specialties requested that entire tab be referred to the CPT Editorial Panel to more accurately describe the service. The RUC supported the referral to CPT and a CPT Workgroup was established to address these issues.

During the review process, a recommendation was made to remove psychoanalysis from the CPT Workgroup process and forward it on to the RUC for review. It was the opinion of all of the provider groups that the work inherent in providing psychoanalysis was the same regardless of who was performing the procedure and there was no need to further refine the descriptor for that service. A request was made and granted by the AMA RUC staff to add this to code to the RUC's September agenda using the data from our original survey.

Survey Process and Data

The following three groups surveyed 90845: the American Psychiatric Association (Psychiatry), the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work). The survey included two separate reference service lists (RSL), one used by the psychiatry, and one used by the psychology and social work. The separate RSL's were reviewed and approved by the RUC Research Subcommittee. Together the societies convened a joint society expert panel ("expert panel") to review the survey data and make recommendations.

Analysis and recommendations from the expert panel

Time: The survey median results regarding time are 10 minutes pre, 50 minutes intra, and 10 minutes post service. The expert panel supported the median time of 50 minutes for the intra-service time however thought that the median values for the pre and post service times were an overestimation. According to the experts, the patient is typically seen face to face for 50 minutes and the total encounter lasts approximately 60 minutes. The panel reviewed the 25th percentile of 5 minutes of pre and 5 minutes for post service work and agreed these times were more representative of what typically occurs. The 5 minutes of pre and post time combined with the intra-service time of 50 minutes results in a total time of 60 minutes. **Therefore we recommend 5 minutes pre, 50 minutes intra and 5 minutes post service time for a total time of 60 minutes.**

RVW: As noted above, two separate reference service lists were used for this survey effort resulting in two different codes being selected as the key reference service. Responses by psychologists and social workers who were using a common reference service list outnumbered the responses by psychiatrists which impacted the selection of the key reference service. The expert panel reviewed the number of times each specialty billed this code using the RUC database and compared it to the response rate by specialty to the RUC survey. They found that psychiatry was under-represented and psychology and social work over-represented in the results.

Specialty	2010 Medicare Claims (Frequency)		Percentage of Responses by Specialty	RVW Median	Median Time			
	%	# Claims			Pre	Intra	Post	Total Time
Psychiatry	50%	2709	36%	2.50	5	50	10	65
Psychology	36%	1950	43%	2.10	10	55	10	75
Social Work	0.12%	7	21%	1.95	15	50	15	80

The key reference service for the combined survey results was 99404, *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (RVW of 1.95 with time of 0, 60, 0, pre, intra and post respectively and a total time of 60 minutes) which was selected by 17 of the 34 psychologists and social workers completing the survey.

An analysis of the intensity and complexity measures shows that respondents thought the intensity and complexity of the work of psychoanalysis was greater in every measure – in particular technical skill (4.53 for 90845 and 3.65 for 99404) and

outcome (4.65 for 90845 and 3.76 for 99404) -- than the key reference service except one, physical effort, validating the median value of 2.10.

Six of the 19 psychiatrists responding to the survey chose CPT code 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* (RVW of 2.11, with times of 5, 35, 15 pre, intra and post respectively and a total time of 55 minutes) as the key reference service.

Again, an analysis of the intensity and complexity measures show that respondents indicated that the work was more intense and/or complex in a majority of the categories, again with the greatest difference in the area of technical skill required (4.83 for 90845 and 3.83 for 99215) and outcome dependent on the skill and judgment of the physician (4.50 for 90845 and 3.50 for 99215), further substantiating the median RVW of 2.10.

The expert panel concurred with the survey median RVW of 2.10, agreeing that psychoanalysis was more intense, required greater technical effort and relied more heavily on the skill and judgment of the clinician than the key reference services cited.

The current RVW for 90845 is 1.79, we guide you to the compelling evidence section for details regarding two compelling evidence criteria which the expert panel believed were met - changes in physician work due to patient population and technique. In addition to the reference service codes identified above, the following service is provided for comparison to support our recommended RVW and times:

CPT 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit*, with a work RVW of 2.00 and 55 minutes of total time (10 pre, 30 intra, 15 post service).

This comparison code, coupled with the median survey results, supports our recommendation of the median value of 2.10 for 90845, Psychoanalysis. **Therefore we recommend the median RVW of 2.10 with times of 5 pre, 50 intra and 5 post service for a total time of 60 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 90845

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

As noted in the letter to CMS, psychoanalysis and the other codes within the psychiatry section were identified by the specialty societies as being misvalued predominately because of changes in the patient population and in the case of psychoanalysis, due to changes to the technique since the code was originally valued in 1995 as described below. The following outlines those changes in addition to the original arguments in the letter to CMS as part of the five-year review process.

(1) Change in the patient population: Psychoanalysts traditionally treated a wide variety of conditions which included a considerable number of high functioning patients who came to treatment for what might be regarded today as relatively minor psychological problems. Patients with such conditions are now often treated in a variety of newer treatment modalities (such as short term cognitive-behavioral and psychodynamic psychotherapies, CPT 90806 or 90807) rather than psychoanalysis. As a result there has been a change in the overall severity of the clinical population engaged in full psychoanalytic treatment (CPT 90845) with an increased number of patients suffering from narcissistic and borderline conditions, as well as patients with dual diagnoses, including bipolar disorder and some forms of substance abuse. Such patients tend to be more unstable both within and outside the treatment setting, and may require a much more active approach on the part of the psychoanalyst. This change in the overall composition of the patient population has resulted in a greater degree of work effort on the part of psychoanalysts, as well as increased stress borne out of concern for possible transitory negative effects (including transitory increases in suicidal ideation) which may occur as an effect of such intensive treatment and which must be carefully managed.

(2) Change in the technique employed in psychoanalytic practice: Traditionally, psychoanalytic treatment (CPT 90845) had been based in a model originated in theoretical writings of Freud and carried into actual practice by psychoanalysts during the mid-20th century. In this model the analyst tended to be silent a great deal of the time, listening closely to the patient's associations and intervening sparsely with interpretations with the aim of augmenting the patient's self-understanding. As a result of growing understanding of the actual role of the psychoanalyst's presence in the session the focus has shifted to a greater emphasis on the interaction between the psychoanalyst and the patient as the data for gaining understanding of the patient's internal dynamics. Technically, this focus on the interpersonal process between them is a further development of the fundamental concepts of transference, counter-transference, and therapeutic change. This technical change had already started to become evident in the 1990's but is now a widely regarded important feature of psychoanalytic treatment. As a result of this technical change the psychoanalyst is required to be much more intently focused on the minute to minute interaction during the session, considerably more active during the session, and much more focused on his or her internal feeling states both within and between the analytic sessions. This substantially increases the psychoanalyst's intensity and complexity effort during the session, when compared with the earlier model.

Five-Year Review Specific Questions

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%).

Has the work of performing this service changed in the past 5 years? Yes 40% No 60%

A. This service represents new technology? Yes 32% No 68%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 0% Same Work: 14% More Work: 86%

B. This service reflects new technology that has become more familiar: Yes 14% No 86%

C. Patients requiring this service are now:
More complex (more work) 91% Less complex (less work) 0% No change in complexity 9%
D. The typical site-of-service has changed:
From outpatient to inpatient 9% From inpatient to outpatient 9% No change 82%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90846 Tracking Number LL13 Original Specialty Recommended RVU: **2.40**
Presented Recommended RVU: **2.40**
Global Period: XXX RUC Recommended RVU: **2.40**

CPT Descriptor: Family psychotherapy (without the patient present)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Parents of a 16 year old girl who is defiant, unruly, failing in school, and recently caught smoking marijuana seek help in managing the child. The child refuses to come in for treatment. The parents disagree on how to manage the child.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare office for family; review patient's records, including information from outside sources; communicate with other professionals.

Description of Intra-Service Work: Face to face interaction with the patient's family; obtain interval history of the patient; provide psychoeducation regarding the patient's problems and the role family members have in perpetuating or diminishing them; formulation of treatment goals; and, development of systemic strategies to achieve desired goals.

Description of Post-Service Work: Arrange for further services; provide electronic, written or telephone communication with other family and other professionals (e.g., physicians, teachers, psychotherapists); document the services provided; provide written, electronic or telephone reports to Medicare or other third party payers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Jeremy Musher, MD; Sherry Barron-Seabrook, MD;James Georgoulakis, PhD; Doris Tomer, LCSW				
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry,American Psychological Association, National Association of Social Workers				
CPT Code:	90846				
Sample Size:	2031	**Resp N:**	123	**Response:** 6.0 %	
Description of Sample:	Random and Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**25.00**	60.00	520.00
Survey RVW:	1.10	1.95	**2.40**	3.00	4.21
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	45.00	**50.00**	60.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90846	**Recommended Physician Work RVU: 2.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99386	XXX	2.33	**RUC Time**	

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.43	**RUC Time**	8,436,133

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family

Other Reference CPT Code	Global	Work RVU	Time Source
99310	XXX	2.35	**RUC Time**

CPT Descriptor Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 17.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 90846**	**Key Reference CPT Code: 99215**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	50.00	35.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**65.00**	**55.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.76	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.43
Urgency of medical decision making	3.71	3.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.19
Physical effort required	1.81	1.81
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.62	3.52
Outcome depends on the skill and judgment of physician	4.33	4.38
Estimated risk of malpractice suit with poor outcome	2.95	3.10

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.76	2.62
Intra-Service intensity/complexity	4.19	4.19

Post-Service intensity/complexity	3.19	3.10

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs)* include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

This code, 90846, Family Psychotherapy (without the patient present) is an existing code and was not revised during the CPT process.

Survey Process
The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC.

The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers, and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

82 percent of the 123 survey respondents indicated that the vignette described the typical patient.

As noted in the work descriptor, the pre-service time is spent collecting and reviewing medical records and other data prior to the family visit. The post time is spent scheduling the next appointment, developing a written treatment plan, following up with other providers/agencies regarding findings, writing referrals for other services, and any other activities that result from the treatment decisions made during the session, again, without benefit of clinical staff to assist. **Therefore we recommend 5 minutes pre-, 50 minutes intra-, and 10 minutes post-service time for a total time of 65 minutes.**

The key reference service for the survey results was 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's*

needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family (5, 35, 15; RVW 2.11), which was selected by 18% of the survey respondents.

An analysis of the intensity and complexity measures shows that respondents thought the intensity and complexity of the work of family therapy (without the patient present) was equal to or higher than the majority of the measures. In particular, the respondents indicated that the technical skill required and the risk of complications was greater in the surveyed code than in the reference code. They rated the intra-service intensity/complexity the same as the reference code with the pre- and post-service periods rated higher for the surveyed code. The expert panel reviewed this data, comparing the reference service code RVW and time to the surveyed code. They agreed that the difference in RVW could be accounted for by the increased time required, as well as by the increased intensity and complexity in specific measures and support the survey median RVW of 2.40.

An additional comparison can be made to 99386, *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years,* (5, 40, 10; RVW 2.33) with a total time of 55 minutes. The increased RVW of the surveyed code accounts for the increased time of the service.

The expert panel also identified 99204, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family*, with a work RVW of 2.43 and 45 minutes of total time (5 pre, 30 intra, 10 post service). In comparing the work of the surveyed code to 99204, the expert panel noted that the difference in time between the two codes supports the median RVW and makes up for any difference in intensity between work for the benefit of an established patient versus work associated with a new patient.

One last comparison was made with 99310, *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention* (15, 35, 20; RVW 2.35), with a total time of 70 minutes. The times and RVW values are similar, again, with the increased intra-service time accounting for the slightly higher RVW of the surveyed code.

Finally, the expert panel compared the results from this survey process with the results from the 2010 survey of this code. The panel thinks that the differences in the median RVWs between the 2012 survey and the 2010 survey (2.40 RVWs vs. 2.00 RVWs) can be accounted for by the increased number of responses (123 responses in the 2012 survey as compared to 76 responses in the 2010 survey) and an increase in the median service performance rate. The expert panel thinks the current survey results are more reliable than the previous survey effort and there is appropriate relativity between the 2012 median value of 2.40 and the values for other psychotherapy services being presented at this meeting.

Recommendation:
The comparisons above support our recommendation of the median value of 2.40 for 90846, Family psychotherapy (without the patient present). **Therefore we recommend the median RVW of 2.40 with times of 10 pre-, 50 intra-, and 15 post-service for a total time of 65 minutes for code 90846.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90846

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Sometimes

Specialty Psychology How often? Sometimes

Specialty Social Work How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 104808
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry Frequency 30195 Percentage 28.80 %

Specialty Psychology Frequency 26621 Percentage 25.39 %

Specialty Social Work Frequency 42856 Percentage 40.89 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 26,202 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry Frequency 7549 Percentage 28.81 %

Specialty Psychology Frequency 6655 Percentage 25.39 %

Specialty Social Work Frequency 10714 Percentage 40.89 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90846

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90847 Tracking Number LL14 Original Specialty Recommended RVU: **2.50**
Presented Recommended RVU: **2.50**
Global Period: XXX RUC Recommended RVU: **2.50**

CPT Descriptor: Family psychotherapy (conjoint psychotherapy) (with patient present)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Parents disagree about how to handle a 14 year old gifted child who is failing in school and violating curfew. The child is disrespectful towards the parents and teachers and refuses to follow standard rules in home and in school.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare office for patient and family; review records, including information obtained from outside sources, communicate with other professionals

Description of Intra-Service Work: Face to face interaction with the patient and family; observation and interpretation of communication and behavior interactions among family members; mental status examination of identified patient consistent with current problem(s); formulation of treatment goals; development of systemic strategies to achieve desired goals; and, provision of psychoeducation as indicated.

Description of Post-Service Work: Arrange for further services; provide written, electronic or telephone communication with other family and other professionals (e.g., physicians, teachers, psychotherapists); document the services provided; provide written, electronic or telephone reports to Medicare or other third party payers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Jeremy Musher, MD; Sherry Barron-Seabrook, MD;James Georgoulakis, PhD; Doris Tomer, LCSW					
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry,American Psychological Association, National Association of Social Workers					
CPT Code:	90847					
Sample Size:	2031	**Resp N:**	123	**Response:** 6.0 %		
Description of Sample:	Random and Convienence					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**60.00**	200.00	1040.00
Survey RVW:	1.10	2.23	**2.50**	3.17	4.25
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	45.00	**55.00**	60.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90847	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**55.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.17	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.61	**RUC Time**	7,451,227

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.43	**RUC Time**	8,436,133

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordinatio

Other Reference CPT Code	Global	Work RVU	Time Source
99336	XXX	2.46	**RUC Time**

CPT Descriptor Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 22.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 90847**	**Key Reference CPT Code:** 99205	**Source of Time RUC Time**
Median Pre-Service Time	5.00	7.00	
Median Intra-Service Time	55.00	45.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**70.00**	**67.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.81	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	3.76
Urgency of medical decision making	3.69	3.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.58	4.13
Physical effort required	2.73	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	3.64
Outcome depends on the skill and judgment of physician	4.38	4.20
Estimated risk of malpractice suit with poor outcome	3.12	3.20

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.44	2.19
Intra-Service intensity/complexity	4.44	4.19

Post-Service intensity/complexity	3.15	2.96

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

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This code, 90847, *Family psychotherapy (conjoint psychotherapy) (with patient present)* is an existing code and was not revised during the CPT process. This code can be used in all settings.

Survey process
The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC.

The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee.

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Analysis and recommendations from the expert panel
The associations involved in this survey convened a joint society expert panel expert panel with broad representation from each group to review the survey data and make recommendations.

84 percent of the survey respondents indicated that the vignette described the typical patient.

As noted in the work descriptor, the pre-service time is spent collecting and reviewing medical records and other data prior to the family visit. The post-service time is spent scheduling the next appointment, developing a written treatment plan, following up with other providers/agencies regarding findings, writing referrals for other services, and any other activities as a result of the treatment decisions from the session, again, without benefit of clinical staff to assist. **Therefore we recommend 5 minutes pre-, 55 minutes intra-, and 10 minutes post service time for a total time of 70 minutes.**

The key reference service chosen for this code was 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the*

patient and/or family (7, 45, 15 ; RVW 3.17) with a total time of 67 minutes, which was selected by 23% of the survey respondents.

An analysis of the intensity and complexity measures shows that respondents thought the intensity and complexity of the work of *Family psychotherapy (conjoint psychotherapy) (with patient present)* was greater than the reference code in many of the measures. In particular, the respondents indicated that the intensity/complexity was greater in each of the time segments than for 99205. The panel believes this data supports the median RVW of 2.50.

An additional comparison can be made to 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit* (15, 40, 20; RVW 2.61). In comparing the two services, the expert panel noted that the times were similar and the variation of the RVW was accounted for by the increased intensity of a new patient in an inpatient setting.

The expert panel also believes the 99336, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver* (10, 40, 15; RVW 2.46), supports the median RVW of the surveyed code based on the similarities in time.

Finally, the expert panel compared the results of the 2012 survey with those of the 2010 survey. The median RVW increased from 1.94 in the 2010 survey to 2.50 in 2012. As with the 90846, there was an increase in the number of survey respondents from 2010 to 2012 (94 to 123). The panel noted that in 2010 there was variation in the median survey responses between the MD and Non-MD groups, which negatively affected the median RVW when the data was combined. The panel thinks that the use of the common reference service list in 2012 led to more reliable survey data with the difference in the median RVW between MDs and Non-MDs at 0.08. The panel also thinks the median value of 2.50 RVWs is in line with the median value for 90846, *Family psychotherapy (without the patient present)*, noting that the work involved is more difficult when the patient is present.

Recommendation
These comparison codes and the median survey results support our recommendation of the median value of 2.50 for 90847, *Family psychotherapy (conjoint psychotherapy) (with patient present)*. **Therefore we recommend the median RVW of 2.50 with times of 5 pre-, 55 intra-, and 10 post- service minutes, for a total time of 70 minutes for 90847.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90847

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry	How often? Sometimes
Specialty Psychology	How often? Sometimes
Specialty Social Work	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 890852
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry	Frequency 171400	Percentage 19.24 %
Specialty Psychology	Frequency 340395	Percentage 38.21 %
Specialty Social Work	Frequency 338257	Percentage 37.97 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 222,713 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 42850	Percentage 19.24 %
Specialty Psychology	Frequency 85099	Percentage 38.21 %
Specialty Social Work	Frequency 84564	Percentage 37.96 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90847

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90853 Tracking Number LL16 Original Specialty Recommended RVU: **0.59**
Presented Recommended RVU: **0.59**
Global Period: XXX RUC Recommended RVU: **0.59**

CPT Descriptor: Group psychotherapy (other than of a multiple-family group)
(Use 9080XE in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Group psychotherapy for adults with similar comorbid medical conditions and psychiatric diagnoses.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review records of each group member; arrange room for the patient group.

Description of Intra-Service Work: Initiation or continuation of psychotherapeutic interventions, including psychoeducation, cognitive behavioral therapy, dialectical behavioral therapy, social skill therapy, psychodynamic therapy, substance abuse therapy and other appropriate techniques. Observation and interpretation of patterns of interaction among patients in group. Interpretation of effects of personality patterns and behaviors on group interactions and on reported behavior outside group. Development of treatment goals for the group as a whole and for individual members.

Description of Post-Service Work: Arrange for further services for each patient; provide written, electronic or telephone communication with each patient's family, if indicated, and other professionals including (e.g. physicians, psychotherapists, courts); document the services provided for each patient; provide written, electronic or telephone reports to Medicare or other third party payers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012					
Presenter(s):	Jeremy Musher, MD; Sherry Barron-Seabrook, MD;James Georgoulakis, PhD; Doris Tomer, LCSW					
Specialty(s):	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry,American Psychological Association, National Association of Social Workers					
CPT Code:	90853					
Sample Size:	1792	**Resp N:**	82	**Response:** 4.5 %		
Description of Sample:	Random and Convenience					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**45.00**	98.00	700.00
Survey RVW:	1.00	2.40	**3.00**	3.55	9.78
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	45.00	60.00	**60.00**	90.00	180.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90853	**Recommended Physician Work RVU: 0.59**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**3.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96153	XXX	0.10	**RUC Time**

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	11,496,707

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
97804	XXX	0.25	**RUC Time**

CPT Descriptor Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 34 **% of respondents:** 41.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 90853**	**Key Reference CPT Code:** 96153	**Source of Time**
Median Pre-Service Time	3.00	1.00	
Median Intra-Service Time	10.00	3.00	
Median Immediate Post-service Time	3.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**16.00**	**5.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.13
Urgency of medical decision making	2.90	2.77
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	3.90
Physical effort required	2.45	2.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.77	2.57
Outcome depends on the skill and judgment of physician	4.00	3.70
Estimated risk of malpractice suit with poor outcome	2.52	2.47

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.61	2.38
Intra-Service intensity/complexity	4.45	4.19
Post-Service intensity/complexity	2.91	2.69

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs)* include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs)* include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

This code, 90853, *Group psychotherapy (other than of a multifamily group)* is an existing code and was not revised during the CPT process. This code can be used in all settings.

Survey Process
The survey was sent to all psychiatrist members of the American Group Psychotherapy Association, and randomly to members of Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. This in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee.

The RUC Research Subcommittee also approved adding to additional questions to the RUC survey regarding group psychotherapy. The societies asked to include a question as to the typical number of patients seen in a typical group session and they asked to include an instruction for the survey respondents to calculate the time and the RVW of the procedure as a whole rather than on a per patient basis. The societies were concerned that survey respondents many respond in an in consistent way if those questions were not included. The RUC Research Subcommittee approved the request.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers, and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

Analysis and recommendations from the expert panel
The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

78 percent of the 82 survey respondents indicated that the vignette described the typical patient and the expert panel concluded that the service performance rate seemed reasonable

The expert panel noted that the median intra-service time of 60 minutes appeared less than what is typical. A review of the data from the 2010 RUC survey of this code shows that the intra-service time was 90 minutes at the median and 75th percentile. Further discussions with experts in group psychotherapy confirmed that the standard length of a typical group psychotherapy visit was 76 to 90 minutes which was reported in the results of a 2010 survey by the American Group Psychotherapy Association. The pre and post service times appeared to be in the appropriate range and in line with the current.

The expert panel does not believe the survey results accurately represent the work of these procedures. We believe that survey respondents were confused by this new way of considering time and work, by using the total work and time of the entire group, rather than considering it by individual patient work and time. This led to an under reporting of values. Despite the increased complexity of patients since the last survey, we don't have credible survey evidence to increase the values, and therefore recommend that the current values should be maintained. We also believe the research Subcommittee should investigate options for future surveys that address procedure codes that describe services provided to groups of patients. The panel requests that the current values be maintained on the basis of the following comparisons.

In comparing 97804, Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes (2,6,2; RVW 0.25), and 99411, Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes 10, 30, 5; RVW 0.15) to *90853, Group Psychotherapy,* the expert panel noted that the complexity of the intra-service work is greater with the surveyed code due to the interpersonal dynamic between participants in the psychotherapeutic process.

The panel also believed that the work of the 90853 was similar to that of the 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. (15, 55, 20; RVW 3.86) which has a similar total time and the higher RVW of the 99223 accounts for the increased intensity of the inpatient service.

Recommendation
We recommend maintaining the current RVW of 0.59 with times of 3 pre-, 10 intra-, and 3 post-service minutes for a total time of 16 minutes (per patient) for 90853.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90853

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry	How often? Commonly
Specialty Psychology	How often? Commonly
Specialty Social Work	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5061420

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total phsyician and clinical services expenses in US.

Specialty Psychiatry	Frequency 1464775	Percentage 28.94 %
Specialty Psychology	Frequency 907513	Percentage 17.93 %
Specialty Social Work	Frequency 1912711	Percentage 37.79 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,265,355 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database.

Specialty Psychiatry	Frequency 366194	Percentage 28.94 %
Specialty Psychology	Frequency 226878	Percentage 17.92 %
Specialty Social Work	Frequency 478178	Percentage 37.79 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90853

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

Table 2

Tab 26 - RUC Summary Data RUC App Values

ISSUE: Psychotherapy

TAB: 26

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME MED	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
	XXX	REF BOTH MDs & Non	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3	86	0.0595			3.17			67	7			45			15
	XXX	CURRENT	90801	Psychiatric diagnostic interview examination		0.0224			2.80			125	10			60			55
LL2	XXX	SVY	90791	Psychiatric diagnostic evaluation	202	0.0369	0.75	2.25	3.00	3.20	6.00	95	15	15	50	60	60	180	20
	XXX	Other	99244	Office consultation for a new or established patient, which requires these 3 key components: A		0.0615			3.02			65	10			40			15
	XXX	Other	95974	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude		0.0313			3.00			110	30			60			20
	XXX	Other	75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress		0.0478			2.95			75	15			50			10
LL2	XXX	REC	90791	Psychiatric diagnostic evaluation		0.0388			3.00			90	10			60			20
	XXX	REF	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3	35	0.0595			3.17			67	7			45			15
	XXX	CURRENT	90801	Psychiatric diagnostic interview examination		0.0224			2.80			125	10			60			55
LL3	XXX	SVY	90792	Psychiatric diagnostic evaluation with medical services	82	0.0430	1.00	3.00	3.25	3.80	15.00	90	10	30	50	60	75	180	20
	XXX	Other	99254	Office consultation for a new or established patient, which requires these 3 key components: A		0.0557			3.29			80	15			45			20
	XXX	Other	99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these		0.0333			3.28			110	15			75			20
	XXX	Other	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including		0.0498			3.24			84	14			50			19.5
LL3	XXX	REC	90792	Psychiatric diagnostic evaluation with medical services		0.0430			3.25			90	10			60			20

Post Presentation/
RUC Approved Values

Table 2

Tab 26 - RUC Summary Data RUC App Values

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX	Time	MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF	96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	115	0.0172			0.46			24	4			15			5
	XXX	CURRENT	90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0403			1.21			30				30			
	XXX	CURRENT	90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0439			1.25			29				29			
LL4	XXX	SVY	90832	Psychotherapy, 30 minutes with patient and/or family member	185	0.0351	0.45	1.00	1.50	1.75	4.00	50	10	1	30	30	30	75	10
	XXX	MPC	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires		0.0466			1.50			40	5			25			10
	XXX	Other	99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An		0.0466			1.50			40	5			25			10
	XXX	Other	94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or		0.0331			1.50			55	15			25			15
LL4	XXX	REC	90832	Psychotherapy, 30 minutes with patient and/or family member		0.0388	1.50					45	5			30			10
	XXX	REF	96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	115	0.0172			0.46			24	4			15			5
	XXX	CURRENT	90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0372			1.86			50				50			
	XXX	CURRENT	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0402			1.89			47				47			
LL6	LL6	SVY	90834	Psychotherapy, 45 minutes with patient and/or family member	185	0.0335	0.98	1.50	2.00	2.35	4.00	67	10	10	45	45	45	95	12
	XXX	MPC	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires		0.0475			2.11			55	5			35			15
	XXX	MPC	94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or		0.0439			1.99			60	15			30			15
	XXX	Other	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual		0.0325			1.95			60	0			60			0
LL6	XXX	REC	90834	Psychotherapy, 45 minutes with patient and/or family member		0.0370	2.00					60	5			45			10
	XXX	REF	96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations	27	0.0214			0.50			23	3			15			5
	XXX	CURRENT	90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0349			2.79			80				80			
	XXX	CURRENT	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0354			2.83			80				80			
LL8	XXX	SVY	90837	Psychotherapy, 60 minutes with patient and/or family member	185	0.0282	0.98	1.95	2.25	3.00	4.00	85	10	0	55	60	60	120	15
	XXX	Other	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3		0.0698			2.43			45	5			30			10
	XXX	Other	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these		0.0443			2.33			65	10			40			15
	XXX	MPC	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires		0.0475			2.11			55	5			35			15
LL8	XXX	REC	90837	Psychotherapy, 60 minutes with patient and/or family member		0.0444	3.00					75	5			60			10

Post Presentation/
RUC Approved Values

Table 2

Tab 26 - RUC Summary Data RUC App Values

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX	Time	MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires	64	0.0466			1.50			40	5			25			10
	XXX	CURRENT	90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0457			1.37			30				30			
	XXX	CURRENT	90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0564			1.41			25				25			
LL5	ZZZ	SVY	+90833	Psychotherapy, 30 minutes with patient and/or family member	114	0.0500	0.48	1.25	1.50	1.60	3.50	30		5	25	30	35	75	
	XXX	Other	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age		0.0550			1.60			35	5			25			5
	XXX	REF	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires	64	0.0466			1.50			40	5			25			10
	XXX	Other	99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An		0.0466			1.50			40	5			25			10
LL5	ZZZ	REC	+90833	Psychotherapy, 30 minutes with patient and/or family member		0.0478			1.50			33				30			3
	XXX	REF	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires	35	0.0466			1.50			24	5			25			10
	XXX	CURRENT	90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0404			2.02			50				50			
	XXX	CURRENT	90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0456			2.05			45				45			
LL7	ZZZ	SVY	+90836	Psychotherapy, 45 minutes with patient and/or family member	114	0.0422	0.65	1.70	1.90	2.00	4.00	45		10	40	45	50	90	
	XXX	Other	99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key		0.0491			1.92			50	10			30			10
	XXX	MPC	99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed		0.0575			1.88			40	5			28			7
LL7	ZZZ	REC	+90836	Psychotherapy, 45 minutes with patient and/or family member		0.0407			1.90			48				45			3
	ZZZ	REF	99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the	35	0.0214			1.77			60				60			
	XXX	CURRENT	90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0369			2.95			80				80			
	XXX	CURRENT	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0381			2.99			79				79			
LL9	ZZZ	SVY	+90838	Psychotherapy, 60 minutes with patient and/or family member	114	0.0350	0.65	1.92	2.10	2.50	5.00	60		15	55	60	70	120	
	XXX	MPC	99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least		0.0480			2.00			55	10			30			15
	XXX	Other	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual		0.0325			1.95			60	0			60			0
LL9	ZZZ	REC	+90838	Psychotherapy, 60 minutes with patient and/or family member		0.0405			2.50			63				60			3

Post Presentation/
RUC Approved Values

Table 2

Tab 26 - RUC Summary Data RUC App Values

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX	Time	MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF	99215	Office or other outpatient visit for the evaluation and management of an established patient, Physicians	22	0.0475			2.11			55	5			35			15
	XXX	CURRENT	90846	Family psychotherapy (without the patient present)		0.0366			1.83			50				50			
LL13	XXX	SVY	90846	Family psychotherapy (without the patient present)	123	0.0368	1.10	1.95	2.40	3.00	4.21	75	10	15	45	50	60	90	15
	XXX	MPC	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3		0.0698			2.43			45	5			30			10
	XXX	Other	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these		0.0443			2.33			65	10			40			15
LL13	XXX	REC	90846	Family psychotherapy (without the patient present)		0.0413			2.40			65	5			50			10
	XXX	REF	99205	Office or other outpatient visit for the evaluation and management of a new patient physicians typically	28	0.0595			3.17			67	7			45			15
	XXX	CURRENT	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	83	0.0326			2.21			76	5			50			21
LL14	XXX	SVY	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	123	0.0353	1.10	2.23	2.50	3.17	4.25	80	10	15	45	55	60	90	15
	XXX	MPC	99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key		0.0457			2.61			75	15			40			20
	XXX	Other	99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires		0.0475			2.46			65	10			40			15
LL14	XXX	REC	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)		0.0393			2.50			70	5			55			10
	XXX	REF BOTH MDs & Non	96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	34	0.0184			0.10			5	1			3			1
	XXX	CURRENT	90853	Group psychotherapy (other than of a multiple-family group)		0.0261			0.59			24	2			14			8
LL15	XXX	SVY/Session	90853	Group psychotherapy (other than of a multiple-family group)	82	0.0369	1.00	2.40	3.00	3.55	9.78	95	15	45	60	60	90	180	20
LL15	XXX	SVY/Patient	90853	Group psychotherapy (other than of a multiple-family group)		0.0369	0.17	0.40	0.50	0.59	1.63	16	3	8	10	10	15	30	3
	XXX	Other	76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete		0.0271			0.63			25	5			15			5
	XXX	MPC	97002	Physical therapy re-evaluation		0.0246			0.60			25	2			18			5
LL15	XXX	REC	90853	Group psychotherapy (other than of a multiple-family group)		0.0456			0.59			16	3			10			3

CPT Code: 90791
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychiatric diagnostic evaluation code

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90791
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychiatric diagnostic evaluation code

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_90792_____
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychiatric diagnostic evaluation with medical services

Global Period:_XXX____ Meeting Date: _April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90792
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychiatric diagnostic evaluation with medical services

Global Period:_XXX____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90832
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 30 minutes with patient and/or family member

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90832
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 30 minutes with patient and/or family member

Global Period:_XXX____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_90833_____
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service

Global Period:_ZZZ____ Meeting Date: _April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_ 90833 _____
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period:_ZZZ____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: _90834_____
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 45 minutes with patient and/or family member

Global Period:_XXX____ Meeting Date: _April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_ 90834_____
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 45 minutes with patient and/or family member

Global Period:_XXX____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_90834_____
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period:_ZZZ____ Meeting Date: _April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_ 90836_____
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period:_ZZZ____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90837
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 60 minutes with patient and/or family member

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_ 90837
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 60 minutes with patient and/or family member

Global Period:_XXX____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period:_ZZZ____ Meeting Date: _April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_ 90838_____
Specialty Society('s)_APA-RUC, AACAP

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period:_ZZZ____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90845
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Psychoanalysis

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90845
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Psychoanalysis

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90846
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Family psychotherapy (without the patient present)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90846
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Family psychotherapy (without the patient present)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90847
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Family psychotherapy (conjoint psychotherapy) (with patient present)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code:_ 90847_____
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Family psychotherapy (conjoint psychotherapy) (with patient present)

Global Period:_XXX____ Meeting Date:_April 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90853
Specialty Society('s) APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Group psychotherapy (other than of a multiple-family group)

(Use 9080XE in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

CPT Code: 90853
Specialty Society('s)_APA-RUC, AACAP, APA-HCPAC, NASW

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
Group psychotherapy (other than of a multiple-family group)

(Use 9080XE in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

	A	B	C	D	E	F	G	H	I	J	K
1											
2				**90791**		**90792**		**90832**		**90834**	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	Psychiatric diagnostic evaluation code		Psychiatric diagnostic evaluation with medical services		Psychotherapy, 30 minutes with patient and/or family member		Psychotherapy, 45 minutes with patient and/or family member	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	Tissues	SK114	box			**0.05**					
58	Patient education booklet	SK062	item			**1**					
59	assessment monitoring instruments	SK005	item			**1**					
60	Reproduced patient worksheet		each								
61											
62											
63	**EQUIPMENT**	**CODE**									
64	One Couch/ Two Chairs	EF042				**1**					
65	Chairs (8)	EF043									
66											
67											
68											
69											

	A	B	C	L	M	N	O	P	Q	R	S
1											
2				**90837**		**90833**		**90836**		**90838**	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	Psychotherapy, 60 minutes with patient and/or family member (Use the 9080XE in		Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and		Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and		Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	Tissues	SK114	box			**0.05**		**0.05**		**0.05**	
58	Patient education booklet	SK062	item								
59	assessment monitoring instruments	SK005	item			**0.25**		**0.25**		**0.25**	
60	Reproduced patient worksheet		each			**0.5**		**0.5**		**0.5**	
61											
62											
63	**EQUIPMENT**	**CODE**									
64	One Couch/ Two Chairs	EF042				**1**		**1**		**60**	
65	Chairs (8)	EF043									
66											
67											
68											
69											

	A	B	C	T	U	V	W	X	Y	Z	AA
1											
2				**90845**		**90846**		**90847**		**90853**	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	Psychoanalysis		Family psychotherapy (without the patient present)		Family psychotherapy (conjoint psychotherapy) (with patient present)		Group psychotherapy (other than of a multiple-family group) (Use 9080XE in	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	Tissues	SK114	box	**0.05**		**0.05**		**0.05**		**0.05**	
58	Patient education booklet	SK062	item								
59	assessment monitoring instruments	SK005	item								
60	Reproduced patient worksheet		each								
61											
62											
63	**EQUIPMENT**	**CODE**									
64	One Couch/ Two Chairs	EF042		**50**		**50**		**55**			
65	Chairs (8)	EF043								**10**	
66											
67											
68											
69											

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE						REFERENCE CODE		REFERENCE CODE			
2				90801		90791		90792		90804		90816		90832	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Psychiatric Diagnostic Interview Examination**		**Psychiatric diagnostic evaluation**		**Psychiatric diagnostic evaluation with medical services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient**		**Psychotherapy, 30 minutes with patient and/or family member**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			57.0	6.0	0.0	0.0	0.0	0.0	20.0	0.0	0.0	6.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			4.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			44.0	0.0	0.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			9.0	6.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	4						1					
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D	5											
18	Provide pre-service education/obtain consent		L037D	12						3					
23	Other: review history, systems and medications		L037D	15											
24	Other: coordination home or outpatient care		L037D	9											
25	Other		L037D							9					
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	9						4					
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D		6								6		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box			0.05		0.05						0.05	
44	Patient education booklet	SK062	item			1		1							
45	assessment monitoring instruments	SK005	item	1		1		1		1				0.25	
46	Reproduced patient worksheet		each											0.5	
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs					1		1						1	
49	Chairs (8)														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE		REFERENCE CODE				REFERENCE CODE		REFERENCE CODE			
2				90806		90818		90834		90808		90821		90837	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient**		**Psychotherapy, 45 minutes with patient and/or family member**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient**		**Psychotherapy, 60 minutes with patient and/or family member**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			11.0	0.0	0.0	6.0	0.0	0.0	11.0	0.0	0.0	6.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			6.0	0.0	0.0	0.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			4.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	1						1					
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D												
18	Provide pre-service education/obtain consent		L037D	3						3					
23	Other: review history, systems and medications		L037D												
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	4						4					
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						6		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box					0.05						0.05	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item	1				0.25		1				0.25	
46	Reproduced patient worksheet		each					0.5						0.5	
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs							1						1	
49	Chairs (8)														

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				REFERENCE CODE		REFERENCE CODE				REFERENCE CODE		REFERENCE CODE			
2				90805		90817		90833		90807		90819		90836	
3	**Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**		**Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services**		**Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**			**20.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**	**20.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**1.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**4.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**	**4.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	**1**						**1**					
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	**3**						**3**					
17	Obtain vital signs		L037D	**4**						**4**					
18	Provide pre-service education/obtain consent		L037D	**3**						**3**					
23	Other: review history, systems and medications		L037D	**5**						**5**					
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	**4**						**4**					
38	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
39	Other Clinical Activity - specify: Coordination of care		L037D				**6**						**6**		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box					**0.05**						**0.05**	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item	**1**				**0.25**		**1**				**0.25**	
46	Reproduced patient worksheet		each					**0.5**						**0.5**	
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs							**1**						**1**	
49	Chairs (8)														

	A	B	C	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1				REFERENCE CODE		REFERENCE CODE				REFERENCE CODE			
2				90809		90822		90838		90845		90845	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services**		**Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service**		**Psychoanalysis**		**Psychoanalysis**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			20.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			15.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			4.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	1						1			
13	**End: When patient enters office/facility for surgery/procedure**												
14	**SERVICE PERIOD**												
15	**Start: When patient enters office/facility for surgery/procedure:**												
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3			
17	Obtain vital signs		L037D	4									
18	Provide pre-service education/obtain consent		L037D	3									
23	Other: review history, systems and medications		L037D	5									
24	Other: coordination home or outpatient care		L037D										
25	Other		L037D										
26	**Intra-service**												
27	**Post-Service**												
28	**End: Patient leaves office**												
29	**POST-SERVICE Period**												
30	**Start: Patient leaves office/facility**												
31	Conduct phone calls/call in prescriptions		L037D	4									
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						
40	**End: with last office visit before end of global period**												
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
43	Tissues		box					0.05				0.05	
44	Patient education booklet	SK062	item										
45	assessment monitoring instruments	SK005	item	1				0.25		1			
46	Reproduced patient worksheet		each					0.5					
47	**EQUIPMENT**	**CODE**											
48	One Couch/ Two Chairs							1				1	
49	Chairs (8)												

	A	B	C	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				90846		90846		90847		90847		90853		90853	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Family psychotherapy (without the patient present)**		**Family psychotherapy (without the patient present)**		**Family psychotherapy (conjoint psychotherapy) (with patient present)**		**Family psychotherapy (conjoint psychotherapy) (with patient present)**		**Group psychotherapy (other than of a multiple-family group)**		**Group psychotherapy (other than of a multiple-family group)**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			11.0	6.0	0.0	0.0	20.0	6.0	0.0	0.0	11.0	6.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			6.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			4.0	6.0	0.0	0.0	4.0	6.0	0.0	0.0	1.0	6.0	0.0	0.0
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	1				1							
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3				3				3			
17	Obtain vital signs		L037D					4				2			
18	Provide pre-service education/obtain consent		L037D	3				3				3			
23	Other: review history, systems and medications		L037D					5				2			
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	4				4				1			
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D		6				6				6		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box			0.05				0.05				0.05	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item												
46	Reproduced patient worksheet		each												
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs					1				1					
49	Chairs (8)													1	

	A	B	C	D	E	F	G	H	I	J	K
1											
2				**90791**		**90792**		**90832**		**90834**	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	Psychiatric diagnostic evaluation code		Psychiatric diagnostic evaluation with medical services		Psychotherapy, 30 minutes with patient and/or family member		Psychotherapy, 45 minutes with patient and/or family member	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	Tissues		box	**0.05**		**0.05**		**0.05**		**0.05**	
58	Patient education booklet	SK062	item	**1**		**1**					
59	assessment monitoring instruments	SK005	item	**1**		**1**		**0.25**		**0.25**	
60	Reproduced patient worksheet		each					**0.5**		**0.5**	
61											
62											
63	**EQUIPMENT**	**CODE**									
64	One Couch/ Two Chairs			**1**		**1**		**1**		**1**	
65	Chairs (8)										
66											
67											
68											
69											

	A	B	C	L	M	N	O	P	Q	R	S
1											
2				**90837**		**90833**		**90836**		**90838**	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	Psychotherapy, 60 minutes with patient and/or family member (Use the 9080XE in		Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and		Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and		Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	Tissues		box	**0.05**		**0.05**		**0.05**		**0.05**	
58	Patient education booklet	SK062	item								
59	assessment monitoring instruments	SK005	item	**0.25**		**0.25**		**0.25**		**0.25**	
60	Reproduced patient worksheet		each	**0.5**		**0.5**		**0.5**		**0.5**	
61											
62											
63	**EQUIPMENT**	**CODE**									
64	One Couch/ Two Chairs			**1**		**1**		**1**		**1**	
65	Chairs (8)										
66											
67											
68											
69											

	A	B	C	T	U	V	W	X	Y	Z	AA
1											
2				**90845**		**90846**		**90847**		**90853**	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	Psychoanalysis		Family psychotherapy (without the patient present)		Family psychotherapy (conjoint psychotherapy) (with patient present)		Group psychotherapy (other than of a multiple-family group) (Use 9080XE in	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	Tissues		box	**0.05**		**0.05**		**0.05**		**0.05**	
58	Patient education booklet	SK062	item								
59	assessment monitoring instruments	SK005	item								
60	Reproduced patient worksheet		each								
61											
62											
63	**EQUIPMENT**	**CODE**									
64	One Couch/ Two Chairs			**1**		**1**		**1**			
65	Chairs (8)									**1**	
66											
67											
68											
69											

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE						REFERENCE CODE		REFERENCE CODE			
2				90801		90791		90792		90804		90816		90832	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Psychiatric Diagnostic Interview Examination**		**Psychiatric diagnostic evaluation**		**Psychiatric diagnostic evaluation with medical services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient**		**Psychotherapy, 30 minutes with patient and/or family member**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			57.0	6.0	0.0	0.0	0.0	0.0	20.0	0.0	0.0	6.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			4.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			44.0	0.0	0.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			9.0	6.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	4						1					
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D	5											
18	Provide pre-service education/obtain consent		L037D	12						3					
23	Other: review history, systems and medications		L037D	15											
24	Other: coordination home or outpatient care		L037D	9											
25	Other		L037D							9					
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	9						4					
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D		6								6		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box			0.05		0.05						0.05	
44	Patient education booklet	SK062	item			1		1							
45	assessment monitoring instruments	SK005	item	1		1		1		1				0.25	
46	Reproduced patient worksheet		each											0.5	
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs					1		1						1	
49	Chairs (8)														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE		REFERENCE CODE				REFERENCE CODE		REFERENCE CODE			
2				90806		90818		90834		90808		90821		90837	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient**		**Psychotherapy, 45 minutes with patient and/or family member**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient**		**Psychotherapy, 60 minutes with patient and/or family member**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			11.0	0.0	0.0	6.0	0.0	0.0	11.0	0.0	0.0	6.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			6.0	0.0	0.0	0.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			4.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	1						1					
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D												
18	Provide pre-service education/obtain consent		L037D	3						3					
23	Other: review history, systems and medications		L037D												
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	4						4					
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						6		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box					0.05						0.05	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item	1				0.25		1				0.25	
46	Reproduced patient worksheet		each					0.5						0.5	
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs							1						1	
49	Chairs (8)														

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				REFERENCE CODE		REFERENCE CODE				REFERENCE CODE		REFERENCE CODE			
2				90805		90817		90833		90807		90819		90836	
3	**Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**		**Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services**		**Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**			**20.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**	**20.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**1.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**4.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**	**4.0**	**0.0**	**0.0**	**6.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	**1**						**1**					
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	**3**						**3**					
17	Obtain vital signs		L037D	**4**						**4**					
18	Provide pre-service education/obtain consent		L037D	**3**						**3**					
23	Other: review history, systems and medications		L037D	**5**						**5**					
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	**4**						**4**					
38	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
39	Other Clinical Activity - specify: Coordination of care		L037D				**6**						**6**		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box					**0.05**						**0.05**	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item	**1**				**0.25**		**1**				**0.25**	
46	Reproduced patient worksheet		each					**0.5**						**0.5**	
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs							**1**						**1**	
49	Chairs (8)														

	A	B	C	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1				REFERENCE CODE		REFERENCE CODE				REFERENCE CODE			
2				90809		90822		90838		90845		90845	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services**		**Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services**		**Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service**		**Psychoanalysis**		**Psychoanalysis**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			20.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			15.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			4.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	1						1			
13	**End: When patient enters office/facility for surgery/procedure**												
14	**SERVICE PERIOD**												
15	**Start: When patient enters office/facility for surgery/procedure:**												
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3			
17	Obtain vital signs		L037D	4									
18	Provide pre-service education/obtain consent		L037D	3									
23	Other: review history, systems and medications		L037D	5									
24	Other: coordination home or outpatient care		L037D										
25	Other		L037D										
26	**Intra-service**												
27	**Post-Service**												
28	**End: Patient leaves office**												
29	**POST-SERVICE Period**												
30	**Start: Patient leaves office/facility**												
31	Conduct phone calls/call in prescriptions		L037D	4									
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						
40	**End: with last office visit before end of global period**												
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
43	Tissues		box					0.05				0.05	
44	Patient education booklet	SK062	item										
45	assessment monitoring instruments	SK005	item	1				0.25		1			
46	Reproduced patient worksheet		each					0.5					
47	**EQUIPMENT**	**CODE**											
48	One Couch/ Two Chairs							1				1	
49	Chairs (8)												

	A	B	C	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				90846		90846		90847		90847		90853		90853	
3	**Meeting Date: April, 2012** **Tab: 26, Psychotherapy** **Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work**	**CMS Code**	**Staff Type**	**Family psychotherapy (without the patient present)**		**Family psychotherapy (without the patient present)**		**Family psychotherapy (conjoint psychotherapy) (with patient present)**		**Family psychotherapy (conjoint psychotherapy) (with patient present)**		**Group psychotherapy (other than of a multiple-family group)**		**Group psychotherapy (other than of a multiple-family group)**	
4	**LOCATION**			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			11.0	6.0	0.0	0.0	20.0	6.0	0.0	0.0	11.0	6.0	0.0	0.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			6.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			4.0	6.0	0.0	0.0	4.0	6.0	0.0	0.0	1.0	6.0	0.0	0.0
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Other Clinical Activity - *specify: Review/Read reports*		L037D	1				1							
13	**End: When patient enters office/facility for surgery/procedure**														
14	**SERVICE PERIOD**														
15	**Start: When patient enters office/facility for surgery/procedure:**														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3				3				3			
17	Obtain vital signs		L037D					4				2			
18	Provide pre-service education/obtain consent		L037D	3				3				3			
23	Other: review history, systems and medications		L037D					5				2			
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	**Intra-service**														
27	**Post-Service**														
28	**End: Patient leaves office**														
29	**POST-SERVICE Period**														
30	**Start: Patient leaves office/facility**														
31	Conduct phone calls/call in prescriptions		L037D	4				4				1			
38	**Total Office Visit Time**			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D		6				6				6		
40	**End: with last office visit before end of global period**														
41	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
43	Tissues		box			0.05				0.05				0.05	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item												
46	Reproduced patient worksheet		each												
47	**EQUIPMENT**	**CODE**													
48	One Couch/ Two Chairs					1				1					
49	Chairs (8)													1	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Wireless Motility Capsule

In February 2012, the CPT Editorial Panel deleted Category III code (0242T) and created a Category I code to describe gastrointestinal tract transit and pressure measurement from the stomach to the colon via wireless capsule.

The RUC reviewed the survey results from 41 gastroenterologists for CPT code 91112 *Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report* and determined that a work RVU of 2.10, the survey's 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey time of 5 minutes pre-service, 40 minutes intra-service and 15 minutes post-service. The RUC compared 91112 to key reference service CPT code 91110 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* (work RVU=3.64) and determined that while code 91112 is a XXX code, 5 minutes of pre service time to capture the face-to-face patient encounter work including informed consent is appropriate for this code and is consistent with other XXX gastrointestinal diagnostic services. The reference service requires twice as much time to perform than 91112, 80 and 40 minutes intra-service time, respectively. The RUC noted that while the quantity of data to be reviewed for 91112 is less than that for 91110, the complexity of the data is greater. For further support the RUC compared 91112 to CPT code 88189 *Flow cytometry, interpretation; 16 or more markers* (work RVU=2.23) and noted that the codes had identical intra-service time. **The RUC recommends a work RVU of 2.10 for CPT code 91112.**

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●91112	Y1	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report. (Do not report 91112 in conjunction with 83986, 91020, 91022, 91117)	XXX	2.10
D0242T		~~Gastrointestinal tract transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report~~ (0242T has been deleted. To report, use code 91112)	YYY	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91112 Tracking Number Y1 Original Specialty Recommended RVU: **2.10**
Presented Recommended RVU: **2.10**
Global Period: XXX RUC Recommended RVU: **2.10**

CPT Descriptor: Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report.

(Do not report 91112 in conjunction with 83986, 91020, 91022, 91117)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female is referred for evaluation of nausea, bloating, abdominal discomfort and constipation. Previous diagnostic studies were negative and confirm absence of a luminal obstructing lesion. The patient has failed to respond to pharmacological therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: Assess for possible contraindications, such as presence of pacemaker, active bowel obstruction or swallowing disorder. Provide education to patient on the nature of the procedure, why it is being performed and possible complications. Provide instructions to patient on preparation for capsule ingestion. Obtain informed consent.

Description of Intra-Service Work: Physician observes patient while ingesting capsule. Patient wears data receiver for 3-7 days while recording transit and pressure measurements. After receiver has been returned to the physician office, the data is downloaded to the computer. The physician proceeds to review the data collected by the reviever.

Description of Post-Service Work: Upon completion of the review and interpretation of the data , a report is prepared and dictated. The findings are communicated to the patient and a copy of the report is sent to the referring physician. The referring physician may also be contacted to discuss the findings.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Nicholas Nickl, MD; Edward Bentley, MD				
Specialty(s):	Gastroenterology (AGA, ASGE)				
CPT Code:	91112				
Sample Size:	184	**Resp N:**	41	**Response:** 22.2 %	
Description of Sample:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**12.00**	20.00	250.00
Survey RVW:	0.97	2.10	**3.38**	3.84	5.24
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	20.00	**40.00**	60.00	90.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	91112	**Recommended Physician Work RVU: 2.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
91110	XXX	3.64	**RUC Time**

CPT Descriptor Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,650,554

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.43	**RUC Time**	8,436,133

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 58.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 91112**	**Key Reference CPT Code:** 91110	**Source of Time** RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	40.00	80.00	
Median Immediate Post-service Time	15.00	15.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**60.00**	**100.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.46	3.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.63	4.17
Urgency of medical decision making	3.50	3.79
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.25	4.08
Physical effort required	3.38	3.46
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.13	3.17
Outcome depends on the skill and judgment of physician	4.38	4.33
Estimated risk of malpractice suit with poor outcome	3.42	3.58

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.75	3.58
Intra-Service intensity/complexity	4.00	3.96
Post-Service intensity/complexity	4.04	3.83

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of 184 gastroenterologists who perform the service described by CPT code 91112; *Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report*. We received 41 responses (22.2%) from physicians familiar with the physician work involved in performing this service. The societies received approval from the Research Subcommittee to conduct a Panel survey consisting of a mix of physicians from a device manufacturer's user list and a random sample of members. The societies convened an Expert Panel to review the survey results and develop society recommendations.

The Panel determined that 41 surveys represented a robust response for this infrequently-performed service, noting that the survey data exhibited good clustering about the medians that accurately captured the data elements for this service. The key reference code identified in the survey was code 91110; *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report.* The Panel felt that code 91110 is an appropriate reference code that describes a service with similarities in physician work to the surveyed code, specifically in that code 91110 also describes a service in which extensive recorded data is analyzed subsequent to the face-to-face patient encounter to develop a procedure report.

While code 91112 is a XXX code, the expert Panel recommended 5 minutes of pre service time to capture the face-to-face patient encounter work including informed consent, which compares appropriately with other XXX gastrointestinal diagnostic services reviewed by the RUC, such as codes 91110 and 91111, with 5 minutes of pre service time.

The survey median intraservice time was 40 minutes. In comparison, the key reference code, 91110, has a work RVU of 3.64 and an intra-service time of 80 minutes. The expert Panel reviewed the physician work and noted that while the quantity of data to be reviewed for 91112 is less than that for 91110, the complexity of the data is greater. The Panel compared this service to other diagnostic procedures describing analysis of gastrointestinal physiologic recordings:

Code	Brief descriptor	Intraservice time	wRVU	RUC reviewed
91010	Esophageal manometry	20	1.28	April 2010
91022	Duodenal manometry	30	1.44	Feb 2005
91035	Esophageal reflux test with attached telemetry electrode	20	1.59	Feb 2004
91110	Gastrointestinal tract imaging, esophagus through ileum	80	3.64	April 2003

The Panel evaluated the procedure for interpretation of the wireless motility capsule tracings. The test is typically 5 days in duration, includes measurement of 3 distinct physiologic parameters, and requires both an overview evaluation of the full tracing as well as a detailed analysis of approximately 40-60 discrete (<5 minute) event episodes during the test period. In comparing the quantity and intensity of analysis required for 91112 with the physiologic studies listed in the table, the Panel concluded that the survey median intraservice time of 40 minutes is correct and represents an intermediate value between the 20-30 minutes of intraservice time for the other GI physiology tests listed (Codes 91010, 91022, 91035) and code 91110, the Key Reference Service (80 minutes).

The survey reported a median RVW of 3.38 and a 25th percentile value of 2.10. In comparing these values with the wRVU of the Key Reference Service, 91110 at 3.64 the Panel noted that there are less data (but of greater intensity) for 91112 than for 91110, and more than for the three physiology codes listed in the table (91010, 91022, and 91035). The Panel concluded that the 25th percentile wRVU of 2.10 more appropriately reflected the work associated with 91112.

The survey indicated a median post service time of 20 minutes. The Panel noted that this is greater than the 15 minutes of post-service time for the key reference code 91110 and code 91010 which was recently reviewed and recommends 15 minutes of post service time for 91112.

Our societies recommend a work RVU at the survey's 25th percentile at an RVU of 2.10 with 5 minutes of preservice time, a median intra service time of 40 minutes and post-service time of 15 minutes. This would result in an IWPUT of 0.041 for 91112. The IWPUT of the key reference code 91110 is 0.04. In addition, the IWPUT of MPC reference codes 99233 and 99204 are 0.048 and 0.0697, respectively. Our societies note that the recommended value for this code fits with both the key reference code and with the additional MPC reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was previously reported with Category III CPT code 0242T. This new Category I CPT code replaces that code. There is no utilization data available for 0242T as it became effective on January 1, 2011.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 2700 Percentage 90.00 %

Specialty Internal Medicine Frequency 300 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service is provided across a varied patient population. It is estimated that approximately 70% of patients are below the Medicare-elegible patient age range and 30% fall within this range.

Specialty Gastroenterology Frequency 810 Percentage 90.00 %

Specialty Internal Medicine Frequency 90 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 91110

SS Rec Summary

ISSUE: Wireless Motility Capsule - 91112

TAB: 27

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	91110	Gastrointestin	NA	0.040			3.64			100	5					80			15
SVY	91112	Gastrointesti nal transit	41	0.057	0.97	2.10	3.38	3.84	5.24	90	30			5	20	40	60	90	20
REC	91112	Gastrointestin	41	0.041			2.10			60	5					40			15

CPT Code: 91112
Specialty Society('s)__AGA, ASGE_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report.

(Do not report 91112 in conjunction with 83986, 91020, 91022, 91117)

Global Period:_**XXX**____ Meeting Date: _**April 26-29, 2012**_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our societies reviewed the service with expert physicians who are familiar with the staff work, supplies and equipment involved in this procedure.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

As the key reference code in the physician work survey, we decided to compare practice expenses to CPT code 91110.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A in facility setting.

Service Clinical Labor Activities:

Staff coordinates office and

Post-Service Clinical Labor Activities:

Staff conducts follow up phone call with patient regarding test results.

CPT Code:_91112_____
Specialty Society(‘s)__AGA, ASGE_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report.

(Do not report 91112 in conjunction with 83986, 91020, 91022, 91117)

Global Period:_**XXX**____ Meeting Date: _**April 26-29, 2012**_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our societies reviewed the service with expert physicians who are familiar with the staff work, supplies and equipment involved in this procedure.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

As the key reference code in the physician work survey, we decided to compare practice expenses to CPT code 91110.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff (RN/LPN/MTA) calibrates and activates the various pieces of equipment including the data recorder, software, wireless capsule and docking station in preparation for the patient to ingest the capsule and wear the recorder home.

Service Clinical Labor Activities:

The staff greets the patient and ensures the appropriate records are available. They educate the patient on how to ingest the standardized meal and capsule, how to operate the equipment and how and when to wear and remove the recording device. The staff prepares the meal and capsule for ingestion and monitors the patient. The staff coordinates the patient’s next office visits and how to return the data recorder.

When the recorder is returned, the staff will sit with the patient to discuss the “events” that took place and were recorded by the patient using the recorder button. This includes reviewing the patient diary of events and marking them on the software depending on what the event was (i.e., bowel movement, meal, exercise, abdominal pain, etc.) for the physician to review during the interpretation of data.

Post-Service Clinical Labor Activities:

Staff collects the recorder and equipment from patient, downloads the data to the computer software system and prepares the data for the physician to review. Staff conducts follow up phone call with patient regarding test results.

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2				91110		91112	
3	**Meeting Date: April 2012** **Tab: 27** **Specialty: Gastroenterology (AGA, ASGE)**	**CMS Code**	**Staff Type**	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report		Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report. (Do not report 911XX1 in conjunction with 83986, 91020, 91022, 91117)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**						
6	**TOTAL CLINICAL LABOR TIME**			**73.0**	**3.0**	**61.0**	**3.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**5.0**	**0.0**	**15.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**65.0**	**0.0**	**41.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3.0**	**3.0**	**5.0**	**3.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Calibrate/activate recorder and equipment	L037D	RN/LPN/MTA			**15**	
13	**End: When patient enters office/facility for surgery/procedure**						
14	**SERVICE PERIOD**						
15	**Start: When patient enters office/facility for surgery/procedure:**						
16	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA			**2**	
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			**10**	
18	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			**2**	
19	Prepare and position patient/ monitor patient	L037D	RN/LPN/MTA			**2**	
20	**Intra-service**						
21	Discuss and track patient events from diary into software	L037D	RN/LPN/MTA			**25**	
22	**Post-Service**						
23	**End: Patient leaves office**						
24	**POST-SERVICE Period**						
25	**Start: Patient leaves office/facility**						
26	Collect equipment from patient and prepare data for review by physician	L037D	RN/LPN/MTA			**2**	
27	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			**3**	**3**
28	**End: with last office visit before end of global period**						
29	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
30	kit, capsule endoscopy w-application supplies (M2A)	SA055	kit	**1**			
31	SmartPill capsule	invoice	item			**1**	
32	pack, minimum multi-specialty visit	SA048	pack	**1**		**1**	
33	SmartBar, standardized meal	invoice	item			**1**	
34	**EQUIPMENT**	**CODE**					
35	Data receiver	invoice				**7200**	
36	Docking station	invoice				**40**	
37	Activation fixture	invoice				**5**	
38	MotiliGI software	invoice				**40**	
39	notebook (Dell Latitute D600)	ED038				**40**	
40	video system, capsule endoscopy (software, computer, monitor, printer)	ES029		**90**			
41	kit, capsule endoscopy recorder	EQ146		**480**			
42	video system, capsule endoscopy, booster drive w-accessories			**10**			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued - Utilization over 30,000 screen

April 2012

Anterior Segment Imaging

In April 2011, the RUC identified CPT code 92286 *Anterior segment imaging with interpretation and report; with specular microscopy and cell analysis* through the Harvard-Valued utilization over 30,000 screen. The utilization for this service was just below 100,000 for the initial Harvard-Valued – Utilization over 100,000 screen based on 2007 Medicare claims data. The specialty society submitted a coding proposal to revise the existing code descriptor to better describe the service. CPT code 92287 *segment imaging with interpretation and report; with fluorescein angiography* is to be reviewed as part of this family of services.

92286
The RUC reviewed the survey data from 51 ophthalmologists and optometrists for CPT code 92286 and determined that the survey median work RVU of 0.40, which is below the current work RVU, and survey pre-time of 5 minutes and intra-service time of 10 minutes appropriately account for the physician work and time required to perform this service. The specialty society indicated and the RUC agreed that the interpretation and report are included as part of the intra-service work. The RUC compared 92286 to 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (work RVU = 0.35) and determined that although 92286 is inherently bilateral and requires 2 minutes less intra-service time to perform than 92025, the survey respondents indicated that it is more intense and complex. **The RUC recommends a work RVU of 0.40 for CPT code 92286.**

92287
The American Academy of Ophthalmology (AAO) indicated that apart from utilizing an image, codes 92286 and 92287 are completely different clinical indications and conditions. These services are also provided by different specialties within ophthalmology. CPT code 92286 is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow-up care of post corneal transplant patients. CPT code 92287 is rarely performed (less than 3000 in 2010) and obtaining valid survey responses would be difficult. AAO indicated that CPT code 92287 may be inadvertently being reported in lieu of CPT code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* since it is designates that an image was made at the same time as the angiogram. Currently, there is no increased work when that is occurring as both have the same work value. The Academy believes that coding education and publication of a CPT Assistant article may help clarify the difference between codes 92287 and 92235. **The RUC recommends that the specialty society develop a CPT Assistant article to clarify the difference between CPT codes 92287 and 92235.**

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Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
92132		Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral (For specular microscopy and endothelial cell analysis, use 92286)		
▲92286	M1	~~Special a~~Anterior segment ~~photography~~ imaging with interpretation and report; with specular ~~endothelial~~ microscopy and endothelial cell ~~count~~ analysis	XXX	0.40
▲92287	M2	with fluorescein angiography	XXX	Refer to CPT Assistant

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April 3, 2012

Barbara Levy, MD
Chair, AMA/Specialty Society RVS Update Committee
American Medical Association
515 North State Street
Chicago, Illinois 60654

Subject: Tab 28 Anterior Segment Imaging—CPT Codes 92286/92287

Dear Dr. Levy,

The American Academy of Ophthalmology at the request of CMS was asked to review CPT *Code 92286 Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count*. This service was identified by Harvard Valued – Utilization-Over 30,000 screen. In April 2011, the RUC recommended that this service be surveyed and that the specialty societies identify and survey any related codes in the family during this LOI process *to avoid rank order anomalies*.

The Academy believes that the service represented by 92286 is a singular service that is not related to any of the other codes represented in this category of *Other Specialized Service* within the CPT book. This is a section of miscellaneous services that do not fit with other services within CPT. When we reviewed 92286 we found that the language and equipment used to perform the endothelial microscopy and cell count has changed and the language needed updated. We also suggested tightening up the photography language and eliminating the word special since it is not well defined. Since another photography code that follows 92286 numerically had the same introductory descriptor language the panel agreed the opening descriptors should be similar and accepted our editorial change for 92287 *Special anterior segment photography with interpretation and report; with fluorescein angiography*. As outlined in our application, we believed this change was editorial and the panel accepted that interpretation.

Apart from utilizing an image, the two services are done for completely different clinical indications and conditions. These services are also provided by different specialties within ophthalmology. CPT 92286 is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow up care of post corneal transplant patients. CPT 92287 is done rarely (less than 3000 in 2010). The code may

inadvertently being reported in lieu of 92235 Fluorescein Angiography since it is designates that an image was made at the same time as the angiogram. Currently there is no increased work when that is occurring as both have the same work value. The Academy believes that coding education and publication of a CPT Assistant article may help clarify the difference between 92287 and 92235.

We appreciate your consideration of this issue and are happy to discuss and answer any further questions at the upcoming RUC meeting.

Sincerely,

Steve Kamenetzky

Stephen A. Kamenetzky, M.D.
AAO RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92286 Tracking Number M1 Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: Anterior segment imaging with interpretation and report; specular microscopy with endothelial cell analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 year old female with visually significant cataracts is noted to have slit-lamp evidence of endothelial dystrophy prior to planned cataract surgery.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient history is reviewed. The correct eye is identified and a time out is prformed. Previous exams are evaluated. A topical anesthetic is placed in both eyes (for those cases in which a contact specular microscope is used). The patient is positioned in front of the instrument.

Description of Intra-Service Work: Images are acquired and reviewed for adequate quality before analysis. Cells to be counted are outlined and marked. Software is used to calculate endothelial cell density. Images and cell density measurements are evaluated. A report is prepared and sent to the referring physician.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Stephen A. Kamenetzky, M.D., David B. Glasser, M.D., Michael Chaglasian, O.D.		
Specialty(s):	American Academy of Ophthalmology and American Optometric Association		
CPT Code:	92286		
Sample Size:	450	**Resp N:** 51	**Response:** 11.3 %
Description of Sample:	A random sample was selected from AOA as well as AAO members who indicated an interest in cornea as well as comprehensive ophthalmologists		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	32.50	500.00
Survey RVW:	0.25	0.35	**0.40**	0.50	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**10.00**	10.00	25.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	92286	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92025	XXX	0.35	**RUC Time**

CPT Descriptor Computerized corneal topography, unilateral or bilateral, with interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
86320	XXX	0.37	**RUC Time**	19,367

CPT Descriptor 1 Immunoelectrophoresis; serum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,352,877

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
93291	XXX	0.43	**RUC Time**

CPT Descriptor Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 47.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 92286**	**Key Reference CPT Code:** 92025	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	12.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**17.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.21	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.17
Urgency of medical decision making	2.75	2.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.54	3.21
Physical effort required	2.50	2.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.13	2.96
Outcome depends on the skill and judgment of physician	3.54	3.46
Estimated risk of malpractice suit with poor outcome	3.04	2.79

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.83	2.79
Intra-Service intensity/complexity	2.96	2.88
Post-Service intensity/complexity	3.29	3.29

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Previously, CPT 92286 *Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count* was chosen for review by CMS because it is Harvard valued with

utilization >30,000**.** The test is used to quantify the number of corneal endothelial cells present and to assess their morphology and health. The test is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow up care of post corneal transplant patients. The technology has improved over the years shortening the time needed to perform the test and analyze the results. Because of the change in technology a descriptor change was requested at CPT and the revised descriptor now reads: *Anterior segment imaging with interpretation and report; specular microscopy and endothelial cell analysis.* The current WRVU is 0.66 with Harvard time of 18 minutes, designated entirely (as was the custom then) intra-service time. It has an XXX global period.

There were 51 respondents (11% response rate) to the joint AAO-AOA survey and over 90% felt that the vignette was typical. The 25th percentile WRVU was 0.35 and the median WRVU 0.40. The median times were 5/10/5 minutes. The predominant reference code chosen was CPT 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report*. The code was RUC reviewed in Feb 2006, is XXX global and has **a WRVU of 0.35** (the survey median in 2006) with times of **5/12/0**. The surveyed code is typically done with an EM service.

An expert consensus panel composed ophthalmologists and optometrists familiar with the RUC process and visual field testing reviewed the survey results. The panel felt that the pre-service time of 5 minutes was appropriate and that the values for intra-service and post-service time should conform to the RUC guideline established for other ophthalmology diagnostic codes. That guideline was that there was no post-service time and all of that physician work, including interpretation and report, should be captured in the intra-service time. After consideration of these factors, the consensus panel adjusted the survey times slightly and is recommending **5/10/0 minutes.** The panel is also recommending the **median survey value of 0.40 WRVU**, which is 0.26 WRVU lower than the current value (40% reduction).

The consensus panel considered the fact that the survey participants assessed the surveyed code as being more intense and complex than the reference code for all but one metric. The surveyed code requires not only review of a large amount of data, but also assessment of a photograph of the corneal endothelium to assess functional viability. That increases the time required to review the test as well as the intensity and complexity of the effort.

There are other codes with similar times and WRVU across all specialties. CPT 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia) (*RUC 2010, XXX) has a WRVU of 0.45 and times 3/10/3. CPT *93291 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis* (RUC 2008,XXX) has a WRVU of 0.43 and times of 5/12/5. CPT 27882, *Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific* (RUC 2010, XXX) has a WRVU of 0.41 with times of 5/11/5.

Using these codes for reference, the consensus panel felt that the median survey value of 0.40 WRVU correctly valued the surveyed service. As noted earlier, this is a 40% reduction from the current value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) This is a diagnostic service that typically accompanies an office visit

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
92002	5	15	5	25	.88	XXX
92004	5	25	10	40	1.82	XXX
92012	5	15	5	25	.92	XXX
92014	5	24	8	37	1.42	XXX
99213	3	15	5	23	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92286

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty Optometry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
113,864 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. RUC Database

Specialty Ophthalmology Frequency 87000 Percentage 76.40 %

Specialty Optometry Frequency 27000 Percentage 23.71 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92286

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
12	**ISSUE:**																																							
13	**TAB:**																																							
14						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**FAC-obs**				**Office**					**Prolonged**			
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57
16	**REF**	**92025**	Computerized corneal topography, unilateral or bilateral, with interpretation and report		**0.020**			**0.35**			**17**	**5**					**12**			**0**																				
17	**CURRENT**	**92286**	Special anterior segment photography with interpretation and report; with specular endothelial		**#DIV/0!**			**0.66**			**18**																													
18	**SVY**	**92286**	Anterior sergment Imaging with interpretation and report; specular microscopy with endothelelial cell		**0.029**			**0.40**			**15**	**5**					**10**			**0**																				
19	**REC**				**0.029**			**0.40**			**15**	**5**					**10**			**0**																				
20																																							
21																																							
22																																							
23																																							
24																																							
25																																							

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Anterior segment imaging with interpretation and report; specular microscopy with endothelial cell analysis

Global Period: **XXX** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The societies convened a panel of experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **This is an existing code so the current inputs for 92286 should be compared.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The ophthalmic tech assures that the appropriate referral forms are complete and that the medical record is available for the physician.

Service Clinical Labor Activities:

The ophthalmic tech ensures that all supplies and equipment are available for the test and imaging. The tech confirms the test and correct side for testing. The tech assists the physician in positioning the patient and ensuring that the patient remains still during the imaging. Once the procedure is completed and the patient has been escorted to the administrative area, the clinical staff does final review of the photos and prepares them for archiving to the record.

Post-Service Clinical Labor Activities:

Not applicable.

	A	B	C	D	E	F	G	H	I
1				Old PE's		NEW PE's			
2				92286		92286		CPT Code #	
3	**Meeting Date: April 2012** **Tab:** **Specialty:Ophthalmology/Optometry**	**CMS Code**	**Staff Type**	Internal eye photography		Internal eye photography		CPT CODE DESCRIPTOR	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**xxx**		**xxx**			
6	**TOTAL CLINICAL LABOR TIME**			**28.0**	**0.0**	**17.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**23.0**	**0.0**	**17.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN	**5**					
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - *specify:*								
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available								
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV					**2**			
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure	L038A	COMT/COT/RN	**18**		**10**			
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff								
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Other Clinical Activity - *specify:review & archive images*	L038A	COMT/COT/RN	**5**		**5**			
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27						
49	99213 36 minutes		36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
1				Old PE's		NEW PE's			
2				92286		92286		CPT Code #	
3	**Meeting Date: April 2012** **Tab:** **Specialty:Ophthalmology/Optometry**	**CMS Code**	**Staff Type**	Internal eye photography		Internal eye photography		CPT CODE DESCRIPTOR	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**xxx**		**xxx**			
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	pack, ophthalmology visit w/o dilation	SA050	pack						
57									
58									
59									
60									
61									
62	**EQUIPMENT**	**CODE**							
63	Lane, Screening	EL006		**18**		**17**			
64	camera, specular microscope	EP 006		**18**		**17**			
65									
66									
67									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
MPC List Screen

January 2012

Percutaneous Coronary Intervention

In October 2010, CPT code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* was identified by the MPC List screen. Since it had not been reviewed in over six years, the Relativity Assessment Workgroup (RAW) requested that the specialty societies survey this code for RUC review. Subsequently, the specialty society referred the code to the CPT Editorial Panel to revise the family of procedures to more accurately describe the current physician work involved in percutaneous coronary interventions. At the October 2011 CPT meeting, the Panel approved 13 new codes to describe these services.

The RUC had significant discussion regarding the proper reporting of a diagnostic coronary angiogram with a percutaneous coronary intervention (PCI). The specialty explained that while a diagnostic angiogram is required for an intervention procedure, these services are typically performed by different physicians. Typically, a complete diagnostic angiogram would be performed on a day prior to the PCI and would be separately reportable. However, in the event that a patient needs the intervention procedure immediately, a diagnostic exam is performed to determine the anatomy and then the intervention service is performed shortly thereafter. If these services are reported on the same day, by the same physician the standard multiple procedure reduction is applied. This policy mirrors the lower extremity revascularization codes approved by the CPT Editorial Panel and RUC in the 2011 cycle.

92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch*
The RUC reviewed the survey results from 79 cardiologists and recommends the following physician time components: 39 minutes pre-service time, 60 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey data and agreed that the 25th percentile of 9.25 work RVUs slightly overestimated the physician work value appropriate for this service. To find a more appropriate value, the RUC compared the surveyed code to CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00). The Committee noted that while the reference code has more intra-service time compared to 92920, 80 minutes compared to 60 minutes, the intensity and complexity is much greater for a physician working on the heart rather than the leg. Given this, the RUC recommends a work RVU of 9.00, a direct crosswalk to 37224, for CPT code 92920. To ensure this value is relative, the RUC compared the surveyed code to CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and noted that while the intra-service times are identical, 60 minutes, the surveyed code is again a more intense procedure and should be valued higher than the reference code. **The RUC recommends a work RVU of 9.00 for CPT code 92920.**

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92921 ***Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery***
The RUC reviewed the survey results from 80 cardiologists and recommends 30 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 4.00 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to the key reference code 37232 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty* (work RVU= 4.00) and noted that while the reference code has more intra-service time compared to 92921, 40 minutes and 30 minutes, respectively, the survyed code is a more intense procedure given the service is performed on the heart as opposed to the leg. Additionally, the Committee reviewed CPT code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (work RVU= 4.12) and agreed that since these two services have identical intra-service time, 30 minutes, they should be valued similarly. **The RUC recommends a work RVU of 4.00 for CPT code 92921.**

92924 ***Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch***
The RUC reviewed the survey results from 73 cardiologists and recommends the following physician time components: 39 minutes pre-service time, 75 minutes intra-service time and post-service time of 30 minutes. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to CPT code 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU=11.00) and noted that while the reference code has 15 minutes more intra-service time, 92924 is a more intense procedure and should be valued the same. Given this comparison, the RUC agreed that a work RVU of 11.00, a direct crosswalk to 37228, is an accurate value for the surveyed code. To ensure this value is relative to the family of services, the RUC took the intra-service time of 92920, 60 minutes, and added half of the intra time of 92921, 15 minutes, to arrive at an intra-service time of 75 minutes, identical to 92924. Adding these times would create the same work RVU, 11.00, as is recommended for 92924. **The RUC recommends a work RVU of 11.00 for CPT code 92924.**

92925 ***Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery***
The RUC reviewed the survey results from 71 cardiologists and recommends 45 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 5.00 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to CPT code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure* (work RVU= 4.94) and noted that the surveyed code has slightly more intra-service time, 45 minutes compared to 40 minutes, and should be valued slightly higher than the reference code. Additionally, the RUC compared 92925 to 92921 and agreed that since 92925 code has 15 minutes more of intra-service time compared to 92921, the recommended work value for 92925 is appropriately valued higher. **The RUC recommends a work RVU of 5.00 for CPT code 92925.**

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92928 ***Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch***

The RUC reviewed the survey results from 79 cardiologists and recommends 39 minutes pre-service time, 71 minutes intra-service time and 30 minutes post-service time. The RUC noted that survey respondents clearly underestimated the intra time to perform this service with a median of 60 minutes. This service includes the entire physician work of 92920 plus the additional placement of intracoronary stent(s). Given the necessary additional physician work, the RUC recommends the 75th percentile intra-service time of 71 minutes. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 10.49 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to CPT code 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.49) and noted that while the reference code have more intra-service time compared to 92928, 90 minutes and 71 minutes, respectively, the intensity of performing stent placement in the heart is much greater than a placement in the leg. Thus the recommended value is appropriately valued relative to other similar services. **The RUC recommends a work RVU of 10.49 for CPT code 92928.**

92929 ***Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery***

The RUC reviewed the survey results from 80 cardiologists and recommends 30 minutes of intra-service time for this add-on code. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to CPT code 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel* (work RVU= 4.44) and noted that the two service have identical intra time, 30 minutes, and should be valued identically. Thus, the RUC recommends a work RVU of 4.44, a direct crosswalk to 33572, for CPT code 92929. To ensure this value is relative within the family of services, the Committee compared this service to the other two add-on codes just reviewed, 92921 and 92925. It was agreed that the work value for 92929 should be higher than 92921 (recommended work RVU= 4.00) due to greater intensity and lower than 92925 (recommended work RVU= 5.00) due to less intra time. **The RUC recommends a work RVU of 4.44 for CPT code 92929.**

92933 ***Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch***

The RUC reviewed the survey results from 73 cardiologists and recommends 39 minutes pre-service time, 85 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to CPT code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU= 12.32) and noted that the physician work is similar, with almost identical intra-service times, 90 minutes compared to 85 minutes. Thus, the Committee agreed that the work RVUs for code 92933 should be directly

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crosswalked to CPT code 61640. To ensure a work RVU of 12.32 is relative within the family, the RUC noted that this service requires the second highest physician time in the family, 154 minutes, and is a very intense and complex procedure to perform relative to the other services. Thus, the RUC agreed that the work RVU for this service should set the upper threshold for work values within the percutaneous coronary intervention family. **The RUC recommends a work RVU of 12.32 for CPT code 92933.**

92934 ***Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery***
The RUC reviewed the survey results from 73 cardiologists and recommends 45 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 5.50 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to the key reference service 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50) and noted that while the reference code has greater total time than 92934, 62 minutes compared to 45 minutes, the codes should be valued the same because the surveyed code is a much more intense procedure than 37234, as indicated by the survey respondents. Additionally, the Committee compared 92934 to the other similar add-on service in this family, 92925, and noted that while both services have identical times, 45 minutes, 92934 is a more intense procedure and should be valued slightly higher. **The RUC recommends a work RVU of 5.50 for CPT code 92934.**

92937 ***Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel***
The RUC reviewed the survey results from 66 cardiologists and recommends 39 minutes pre-service time, 60 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to 92928 (recommended work RVU= 10.49) and noted that while 92928 has slightly more total time compared to 92937, 140 minutes and 129 minutes, respectively, 92937 is a more intense procedure and should be valued the same. To ensure a work RVU of 10.49 is relative to other similar services, the Committee reviewed CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00) and agreed that while the reference code has more total time, 158 minutes compared to 129 minutes, 92937 is a more intense procedure than 37224 and should be valued higher. **The RUC recommends a work RVU of 10.49 for CPT code 92937.**

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92938 ***Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft***
The RUC reviewed the survey results from 67 cardiologists and recommends 60 minutes of intra-service time for this add-on code. The RUC reviewed the survey results and noted that the survey's median work RVU of 6.00 is a more appropriate value given intensity involved in the service and to maintain appropriate rank order within the family. The RUC compared 92938 to the similar add-on service 92934 (recommended work RVU= 5.50) and agreed that with 15 minutes more intra-service time, 60 minutes compared to 45 minutes, 92938 must be valued higher than 92934. In addition, the Committee compared the surveyed code to key reference service 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50) and noted that while the two service have identical intra-service time, 60 minutes, 92938 is a more intense procedure compared to the reference code and should be valued slightly higher. **The RUC recommends a work RVU of 6.00 for CPT code 92938.**

92941 ***Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel***
The RUC reviewed the survey results from 67 cardiologists and recommends 39 minutes pre-service time, 70 minutes intra-service time and 40 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to 92933 (recommended work RVU= 12.32) and noted that the total physician times for these two services are almost identical, 149 minutes compared to 154 minutes, and should have identical work RVUs of 12.32. The Committee also confirmed that 92933 sets the upper threshold for physician work and intensity in this family of services. To ensure this value aligns itself to similar services, the RUC reviewed key reference service 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 15.00). While 92941 is a more intense procedure, the reference code has significantly more total time, 213 minutes compared to 149 minutes, and should be valued higher than the surveyed code**. The RUC recommends a work RVU of 12.32 for CPT code 92941.**

92943 ***Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel***
The RUC reviewed the survey results from 65 cardiologists and recommends 39 minutes pre-service time, 90 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to 92933 (recommended work RVU=12.32) and determined since both services have almost identical total times, 154 minutes and 159 minutes, respectively, the work value should be identical. . The Committee also confirmed that 92933 sets the upper threshold for physician work and intensity in this family of services. To

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ensure a work value of 12.32 is appropriate for 92943, the RUC reviewed the key reference service 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 15.00). While 92943 is a more intense procedure, the reference code has significantly more total time, 213 minutes compared to 159 minutes, and should be valued higher than the surveyed code**. The RUC recommends a work RVU of 12.32 for CPT code 92943.**

92944

The RUC reviewed the survey results from 64 cardiologists and recommends 60 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 6.00 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to the key reference service 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50) and noted that while the two service have identical intra-service time, 60 minutes, 92944 is a more intense procedure compared to the reference code and should be valued slightly higher. To ensure relativity within the family of service, the Committee compared 92944 to analogous add-on code 92938 (recommended work RVU= 6.00) and agreed that given the identical times and similar intensity and complexity, these two service should valued the same. **The RUC recommends a work RVU of 6.00 for CPT code 92944.**

CPT Discussion:

In order to clarify the correct reporting of a complete diagnostic angiography and these percutaneous coronary intervention procedures, the RUC requests that the CPT Editorial Panel, working with the specialty society, add clarifying introductory language further explaining the specific criteria for separately reporting the two services or that the services may be reported on the same day. The CPT Editorial Panel in February 2012, reviewed this request and made necessary additions to the introductory language.

Work Neutrality:

The RUC noted that under the old coding system placing a stent in a major coronary artery and one stent in one branch resulted in billing one CPT code (92980). In the new coding system, this scenario will result in billing two CPT code (92928 and 92929). While additional CPT codes will be reported under this system, the subsequent reductions in work values results in a budget neutrality savings of 17% to be redistributed back into Medicare payment.

Practice Expense:

These services are primarily performed in the facility setting and no direct practice expense inputs are recommended.

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
37205		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel (For radiological supervision and interpretation, use 75960) (For transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216) (For transcatheter placement of intracranial stents, use 61635) (For transcatheter coronary stent placement, see 92928-9294~~92980, 92981~~) (For transcatheter stent placement of Extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T) (For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)	000	8.27 (No Change)
37207		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel	000	8.27 (No Change)

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✚37208		each additional vessel (List separately in addition to code for primary procedure) (Use 37208 in conjunction with 37207) (For radiological supervision and interpretation, use 75960) (For catheterizations, see 36215-36248) (For transcatheter placement of intracoronary stent(s), see 92928-9294~~92980, 92981~~)	ZZZ	4.12 (No Change)
Radiology **Diagnostic Radiology (Diagnostic Imaging)** **Vascular Procedures** **Transcatheter Procedures**				
✚75968		Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) (Use 75968 in conjunction with 75966) (For percutaneous transluminal coronary angioplasty, see 92920-9294~~92982-92984~~)	ZZZ	0.36 (No Change)
Medicine **Cardiovascular** **Therapeutic Services and Procedures**				

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Codes 92920-92944 describe percutaneous revascularization services performed for occlusive disease of the coronary vessels (major coronary arteries, coronary artery branches, or coronary artery bypass grafts). These percutaneous coronary intervention (PCI) codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. These PCI codes all include the work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, closure of the arteriotomy when performed through the access sheath, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. These codes include angioplasty (eg, balloon, cutting balloon, wired balloons, cryoplasty), atherectomy (eg, directional, rotational, laser), and stenting (eg, balloon expandable, self-expanding, bare metal, drug eluting, covered). Each code in this family includes balloon angioplasty, when performed. Diagnostic coronary angiography is reported separately.

Major coronary arteries: The major coronary arteries are the left main, left anterior descending, left circumflex, right, and ramus intermedius arteries. All PCI procedures performed in all segments (proximal, mid, distal) of a single major coronary artery through the native coronary circulation are reported with one code. When one segment of a major coronary artery is treated through the native circulation and treatment of another segment of the same artery requires access through a coronary artery bypass graft, the intervention through the bypass graft is reported separately.

Coronary artery branches: Up to two coronary artery branches of the left anterior descending (diagonals), left circumflex (marginals), and right (posterior descending, posterolaterals) coronary arteries are recognized. The left main and ramus intermedius coronary arteries do not have recognized branches for coding purposes. All PCI(s) performed in any segment (proximal, mid, distal) of a coronary artery branch is reported with one code. PCI is reported for up to two branches of a major coronary artery. Additional PCI in a third branch of the same major coronary artery is not separately reportable.

Coronary artery bypass grafts: Each coronary artery bypass graft represents a coronary vessel. A sequential bypass graft with more than one distal anastomosis represents only one graft. A branching bypass graft (eg, Y graft) represents a coronary vessel for the main graft, and each branch off the main graft constitutes an additional coronary vessel. PCI performed on major cor-onary arteries or coronary artery branches by access through a bypass graft is reported using the bypass graft PCI codes. All bypass graft PCI codes include the use of coronary artery embolic protection devices when performed.

Only one base code from this family may be reported for revascularization of a major coronary artery and its recognized branches. Only one base code should be reported for revascularization of a coronary artery bypass graft, its subtended coronary artery, and recognized branches of the subtended coronary artery. If one segment of a major coronary artery and its recognized branches is treated through the native circulation, and treatment of another segment of the same vessel requires access through a coronary artery bypass graft, an additional base code is reported to describe the intervention performed through the bypass graft. The PCI base codes are 92920, 92924, 92928, 92933, 92937, 92941, and 92943. The PCI base code inclusive of the most intensive service provided for the target vessel should be reported.

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PCI performed during the same session in additional recognized branches of the target vessel should be reported using the applicable add-on code(s). The add-on codes are 92921, 92925, 92929, 92934, 92938, and 92944 and follow the same principle in regard to reporting the most intensive service provided.

PCI performed during the same session in additional major coronary or in additional coronary artery bypass grafts should be reported using the applicable additional base code(s). PCI performed during the same session in additional coronary artery branches should be reported using the applicable additional add-on code(s).

If a single lesion extends from one target vessel (major coronary artery, coronary artery bypass graft, or coronary artery branch) into another target vessel, but can be revascularized with a single intervention bridging the two vessels, this PCI should be reported with a single code despite treating more than one vessel. For example, if a left main coronary lesion extends into the proximal left circumflex coronary artery and a single stent is placed to treat the entire lesion, this PCI should be reported as a single vessel stent (92928). In this example, a code for additional vessel treatment (92929) would not be additionally reported.

When bifurcation lesions are treated, PCI is reported for both vessels treated. For example, when a bifurcation lesion involving the left anterior descending artery and the first diagonal artery is treated by stenting both vessels, 92928 and 92929 are both reported.

Target vessel PCI for acute myocardial infarction is inclusive of all balloon angioplasty, atherectomy, stenting, manual aspiration thrombectomy, distal protection, and intracoronary rheolytic agent administration performed. Mechanical thrombectomy is reported separately.

Chronic total occlusion of a coronary vessel is present when there is no antegrade flow through the true lumen, accompanied by suggestive angiographic and clinical criteria (eg, antegrade "bridging" collaterals present, calcification at the occlusion site, no current presentation with ST elevation or Q wave acute myocardial infarction attributable to the occluded target lesion). Current presentation with ST elevation or Q wave acute myocardial infarction attributable to the occluded target lesion, subtotal occlusion, and occlusion with dye staining at the site consistent with fresh thrombus are not considered chronic total occlusion.

Codes 92973 (percutaneous transluminal coronary thrombectomy, mechanical), 92974 (coronary brachytherapy), 92978 and 92979 (intravascular ultrasound), and 93571 and 93572 (intravascular Doppler velocity and/or pressure [fractional flow reserve (FFR) or coronary flow reserve (CFR)]) are add-on codes for reporting procedures performed in addition to coronary and bypass graft diagnostic and interventional services, unless included in the base code. Non-mechanical, aspiration thrombectomy is not reported with 92973, and is included in the PCI code for acute myocardial infarction (92941), when performed.

(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974)

(For intravascular radioelement application, see 77785-77787)

(For nonsurgical septal reduction therapy [eg, alcohol ablation], use 93799

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⊙●92920	N1	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	000	9.00
⊙+●92921	N2	each additional branch of a major coronary artery (List separately in addition to code for primary procedure) (Use 92921 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943)	ZZZ	4.00
⊙●92924	N3	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	000	11.00
+⊙●92925	N4	each additional branch of a major coronary artery (List separately in addition to code for primary procedure) (Use 92925 in conjunction with 92924, 92928, 92933, 92937, 92941, 92943)	ZZZ	5.00
⊙●92928	N5	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	000	10.49
⊙+●92929	N6	each additional branch of a major coronary artery (List separately in addition to code for primary procedure) (Use 92929 in conjunction with ~~92924~~, 92928, 92933, 92937, 92941, 92943)	ZZZ	4.44
⊙●92933	N7	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	000	12.32
⊙+●92934	N8	each additional branch of a major coronary artery (List separately in addition to code for primary procedure) (Use 92934 in conjunction with 92933, 92937, 92941, 92943)	ZZZ	5.50

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⊙●92937	N9	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	000	10.49
⊙+●92938	N10	each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure) (Use 92938 in conjunction with 92937)	ZZZ	6.00
⊙●92941	N11	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed;, single vessel (For additional vessels treated, see 92920-92938, 92943, 92944)	000	12.32
⊙●92943	N12	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	000	12.32
⊙●+92944	N13	each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure) (Use 92944 in conjunction with 92924, 92928, 92933, 92937, 92941, 92943) (To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974) (For intravascular radioelement application, see 77785-77787)	ZZZ	6.00

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⊙+ ▲92973		Percutaneous transluminal coronary thrombectomy, mechanical (List separately in addition to code for primary procedure) (Use 92973 in conjunction with 92975, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 93454-93461, 93563, 9356492980, 92982) (Do not use 92973 for aspiration thrombectomy)	ZZZ	3.28 (No Change)
⊙+ 92978		Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure) (Use 92978 in conjunction with 92975, 92980, 92982, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92995, 93454-93461, 93530-93533, 93563, 93564)	ZZZ	0.00 (No Change)
⊙+ 93571		Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary (Use 93571 in conjunction with 92975, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 93454-93461, 93563, 93564)	ZZZ	0.00 (No Change)
⊙+ 93572		each additional vessel (List separately in addition to code for primary procedure) (Use 93572 in conjunction with 93571) (Intravascular distal coronary blood flow velocity measurements include all Doppler transducer manipulations and repositioning within the specific vessel being examined, during coronary angiography or therapeutic intervention [eg, angioplasty]) (For unlisted cardiac catheterization procedure, use 93799)	ZZZ	0.00 (No Change)

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D ⊙ 92980		~~Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel~~	000	N/A
D ⊙ +92981		~~each additional vessel (List separately in addition to code for primary procedure)~~ ~~(Use 92981 in conjunction with 92980)~~ ~~(Codes 92980, 92981 are used to report coronary artery stenting. Coronary angioplasty [92982, 92984] or atherectomy [92995, 92996], in the same artery, is considered part of the stenting procedure and is not reported separately. Codes 92973 [percutaneous transluminal coronary thombectomy] and 92974 [coronary brachytherapy] are add-on codes for reporting procedures performed in addition to coronary stenting, atherectomy, and angioplasty and are not included in the "therapeutic interventions" in 92980). Codes 92978 and 92979 are add-on codes for reporting intravascular ultrasound procedures performed in addition to coronary and bypass graft diagnostic and interventional services.~~ ~~(To report additional vessels treated by angioplasty or atherectomy only during the same session, see 92984, 92996)~~ ~~(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974)~~ ~~(For intravascular radioelement application, see 77785-77787)~~	ZZZ	N/A
D ⊙ 92982		~~Percutaneous transluminal coronary balloon angioplasty; single vessel~~	000	N/A

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D+92984		~~each additional vessel (List separately in addition to code for primary procedure)~~ ~~(Use 92984 in conjunction with 92980, 92982, 92995)~~ ~~(For stent placement following completion of angioplasty or atherectomy, see 92980, 92981)~~ ~~(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974)~~ ~~(For intravascular radioelement application, see 77785-77787)~~ (92980-92984 have been deleted. To report, see 92920-92944)	ZZZ	N/A
D92995		~~Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel~~	000	N/A
D +92996		~~each additional vessel (List separately in addition to code for primary procedure)~~ (92995, 92996 have been deleted. To report, see 92924, 92925, 92933-92944)	ZZZ	N/A

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Cardiac Catheterization

Cardiac catheterization is…

Right heart catheterization…

The cardiac catheterization…

For cardiac catheterization…

Cardiac catheterization (93451-93461)…

When cardiac catheterization is combined with pharmacologic agent administration with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, use 93463 in conjunction with 93451-93453 and 93456-93461. Do not report 93463 for intracoronary administration of pharmacologic agents during percutaneous coronary interventional procedures, during intracoronary assessment of coronary pressure, flow or resistance, or during intracoronary imaging procedures. Do not report 93463 in conjunction with 92975, 92977, 92920-92944~~92980, 92982, or 92995~~.

⊙+ 93463		Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after, and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure) (Use 93463 in conjunction with 93451-93453, 93456-93461, ~~93530-93533~~ 93563, 93564) (Report 93463 only once per catheterization procedure) (Do not report 93463 for pharmacologic agent administration in conjunction with coronary interventional procedure codes 92975, 92977, 92920-92944 ~~92980, 92982, 92995~~)	ZZZ	2.00 (No Change)

Category III

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✚0205T		Intravascular catheter-based coronary vessel or graft spectroscopy (eg, infrared) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation, and report, each vessel (List separately in addition to code for primary procedure) (Use 0205T in conjunction with 92975, 92920, 92924, 92928, 92933, 92937, 92941, 92943, ~~92980, 92982, 92995,~~ ~~9345~~93454-~~9346~~9346~~293530 93533,~~ 93563, 93564)	ZZZ	Carrier Priced
0262T		Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach Sunset January 2017 (0262T includes all congenital cardiac catheterization[s], intraprocedural contrast injection[s], fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 0262T in conjunction with 76000, 76001, 93530, 93563, 93566-93568) (0262T includes percutaneous balloon angioplasty/valvuloplasty of the pulmonary valve/conduit. Do not report 0262T in conjunction with 92990) (0262T includes stent deployment within the pulmonary conduit. Do not report 37205, 37206, 75960 for stent placement within the pulmonary conduit. Report 92928-92944 ~~92980, 92981~~, 37205, 37206, 75960 separately when cardiovascular stent placement is performed at a site separate from the prosthetic valve delivery site. Report 92997, 92998 separately when pulmonary artery angioplasty is performed at a site separate from the prosthetic valve delivery site)	000	Carrier Priced

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⊙✚0291T		*Intravascular optical coherence tomography (coronary native vessel or graft) during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation, and report; initial vessel (List separately in addition to primary procedure)* (Use 0291T~~, 0292T~~ in conjunction with cardiac catheterization codes 92975, ~~92980, 92982~~, ~~92995~~, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 93454-93461, ~~and 93530-93533 [when angiography is additionally performed and reported with~~ 93563, 93564~~]~~)	ZZZ	Carrier Priced
⊙✚0292T		each additional vessel (List separately in addition to primary procedure) (Use 0292T in conjunction with 0291T) ~~(Use 0291T, 0292T in conjunction with cardiac catheterization codes 92975, 92980, 92982, 92995, 93454-93461, and 93530-93533 [when angiography is additionally performed and reported with 93563, 93564])~~	ZZZ	Carrier Priced

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92920 Tracking Number N1 Original Specialty Recommended RVU: **9.25**
Presented Recommended RVU: **9.25**
Global Period: 000 RUC Recommended RVU: **9.00**

CPT Descriptor: Percutaneous transluminal coronary angioplasty; single major coronary artery or branch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with progressive unstable angina. Stress testing shows anterior ischemia. Coronary arteriography demonstrates diffusely diseased diabetic-appearing coronary arteries with a 90% calcified lesion in the distal part of a tortuous left anterior descending coronary artery. The size of the vessel is less than the size of the smallest available stent. The patient is transferred to a PCI center for percutaneous coronary balloon angioplasty on the following day. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. Physical examination is conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the

pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow. The coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92920				
Sample Size: 418	**Resp N:** 79	**Response:** 18.8 %			
Sample Type: Random	**Additional Sample Information:** random+panel of several committees				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	100.00	250.00
Survey RVW:	3.00	9.25	**11.00**	13.40	21.55
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	45.00	**60.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code: 92920	**Recommended Physician Work RVU: 9.00**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:	**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**5.00**	**5.00**	**0.00**
Intra-Service Time:	**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37225	000	12.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	40,374

CPT Descriptor 1 Tracheostomy, planned (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33973	000	9.75	**RUC Time**	128

CPT Descriptor 2 Insertion of intra-aortic balloon assist device through the ascending aorta

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 22.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 92920**	**Key Reference CPT Code:** 37225	**Source of Time RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	60.00	118.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**129.00**	**196.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	3.72
Urgency of medical decision making	4.39	3.44
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.39	4.06
Physical effort required	4.00	4.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.78	3.89
Outcome depends on the skill and judgment of physician	4.72	4.28
Estimated risk of malpractice suit with poor outcome	4.50	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.56
Intra-Service intensity/complexity	4.11	3.94
Post-Service intensity/complexity	3.56	3.39

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ACC and SCAI convened a panel of physicians familiar with the services to review the survey data. The survey was robust and was completed by physicians who have experience with the service. Code 92920 will be used to report percutaneous transluminal coronary angioplasty of a single major coronary artery or branch. The panel reviewed the

preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37225, femoral/popliteal revascularization with atherectomy. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92920 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 8-23% higher for the new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92982

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 53812
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 26,848 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty.

Please explain the rationale for this estimate. We predict 9298X1 will be used to report 100% of the procedures previously reported with 92982. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92982

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92921 Tracking Number N2 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: ZZZ RUC Recommended RVU: **4.00**

CPT Descriptor: Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with progressive unstable angina. Stress testing shows anterior ischemia. Coronary arteriography demonstrates diffusely diseased diabetic-appearing coronary arteries with a 90% calcified lesion in the distal part of a tortuous left anterior descending coronary artery. An additional 80% calcific lesion is noted in the first diagonal artery. The size of the vessels is less than the size of the smallest available stent. The patient is transferred to a PCI center for percutaneous coronary balloon angioplasty on the following day. The first lesion has been treated. Now an additional lesion is to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The indwelling guide catheter from the first coronary intervention is removed over a guide wire. A new guide is selected to engage the second vessel. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous

panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device ("indeflator") is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow. The coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92921				
Sample Size:	418	**Resp N:**	80	**Response:** 19.1 %	
Sample Type:	Random	**Additional Sample Information:**	random+panel of several committees		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**30.00**	70.00	200.00
Survey RVW:	2.10	4.00	**5.00**	6.50	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	25.00	**30.00**	45.00	250.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	92921	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37232	ZZZ	4.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13133	ZZZ	2.19	**RUC Time**	10,120

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	120,570

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 92921**	**Key Reference CPT Code:** 37232	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**42.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.42	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.38	3.92
Urgency of medical decision making	4.42	3.58
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.52	4.22
Physical effort required	3.70	3.78
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.54	3.88
Outcome depends on the skill and judgment of physician	4.75	4.33
Estimated risk of malpractice suit with poor outcome	4.38	3.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.83	3.63
Intra-Service intensity/complexity	4.46	4.13
Post-Service intensity/complexity	3.57	3.33

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92921 is an add-on code to 92920 that will be used to report additional branch(es) of a major coronary artery. The survey was robust and was completed by physicians who have experience with the service.

They key reference code is 37232, additional tibial/peroneal revascularization with angioplasty. This is a longer, less intense service. Key reference respondents felt surveyed code 92921 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 7-23% higher for the new code.

The panel notes that it is difficult to make a time comparison of the survey to the current code, which has 83 minutes of CMS/Other time. That time is 3 minutes longer than the intraservice time of the current base code for angioplasty (92982). Our research did not produce any further information for how that 83 minutes was derived.

Due to these considerations and the broader issues of rank order and new coding conventions discussed in the attached overview, the panel recommends the 25th percentile work value of 4.00 for this service. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92984

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14064
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,368
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X2 will be used to report 103% of the procedures previously reported with 92984. This rate was then applied to 2010 utilization data.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92984

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92924 Tracking Number N3 Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **12.00**
Global Period: 000 RUC Recommended RVU: **11.00**

CPT Descriptor: Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old male with diffuse peripheral vascular disease presents with chronic stable angina refractory to medical therapy. Stress testing shows inferior ischemia at a low level of cardiac stress. Coronary arteriography demonstrates heavily calcified coronary arteries. The left anterior descending and circumflex coronary arteries are relatively free of occlusive disease but the right coronary artery has a long heavily calcified lesion which is 50% stenotic throughout and 80% stenotic at the worst point. The patient is transferred to a PCI center for percutaneous coronary rotational atherectomy on the following day. The result after rotational atherectomy and angioplasty is "stent-like", and passage of a stent would be difficult due to proximal calcification and tortuosity, so stenting is not performed. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. Physical examination is conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the

dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. The coronary guide wire is then removed through the balloon lumen and replaced with a wire specifically designed for rotational atherectomy. The balloon is removed over the wire. Balloon position is confirmed by angiography.

An appropriate sized rotational atherectomy burr is selected and the rotational atherectomy system is assembled and attached to a Rotablator Console. A Rotablator Foot Pedal is positioned under the table. The burr delivery unit is loaded with extreme care over the rotablator wire as the latter is very susceptible to kinking. If kinked the wire must be removed from the coronary and the entire process to this point is redone. Rotaflush is administered as a continuous infusion to prevent no-reflow. The burr is activated outside the body to test the rotational speed and the console is used to adjust the speed to a proper level.
The burr is advanced over the rotablator wire to the coronary artery proximal to the lesion. This typically requires carefully coordinated pulling of the wire during burr advancement to overcome resistance. The burr is adjusted to remove tension from the system. The device is activated to test the rotational speed in the body and adjusted as needed. Careful monitoring of the rhythm and blood pressure is performed as bradycardia and hypotension frequently occur. Once the test is complete, the burr is activated and advanced in a gradual back and forth motion to ablate calcific plaque. Typically the patient develops chest pain and/or electrocardiographic changes during these “runs”, which are kept short to avoid severe hypotension, bradycardia and even heart block. Angiography is performed in between runs to assess coronary flow and to ensure no dissection or perforation. The operator must wait up to several minutes between runs to allow resolution of ischemia. Multiple runs are performed with the burr until it is able to progress through the resistant lesion. Polishing runs are then performed. The burr is exchanged out over the wire. A larger burr is then selected to enlarge the lumen more optimally. The same procedure is then performed with the larger burr. After several progressively larger burrs and successful enlargement of the lumen, balloon angioplasty is typically performed to smooth out irregularities and seal any atheromatous flaps up against the vessel wall to try to prevent abrupt vessel closure.

An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide.

Intracoronary vasodilators are again administered. Angiography is performed in multiple views. Once an adequate expansion is achieved, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow. The coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92924				
Sample Size:	418	**Resp N:**	73	**Response:** 17.4 %	
Sample Type:	Random	**Additional Sample Information:**	random+panel of several committees		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	20.00	200.00
Survey RVW:	3.40	12.00	**14.50**	15.50	30.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	60.00	**75.00**	90.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	92924	**Recommended Physician Work RVU: 11.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37229	000	14.05	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11044	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 28.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 92924**	**Key Reference CPT Code:** 37229	**Source of Time RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	75.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**144.00**	**198.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.71	4.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.62	4.10
Urgency of medical decision making	4.52	3.81
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.90	4.57
Physical effort required	4.62	4.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.90	4.24
Outcome depends on the skill and judgment of physician	4.90	4.48
Estimated risk of malpractice suit with poor outcome	4.67	3.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.29	4.00
Intra-Service intensity/complexity	4.81	4.48
Post-Service intensity/complexity	4.05	3.86

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92924 will be used to report coronary atherectomy in a major coronary artery or branch. It includes angioplasty when performed. The survey was robust and was completed by physicians who have experience with the service. The panel reviewed the preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37229, tibial/peroneal revascularization with atherectomy and angioplasty when performed. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92924 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 7-21% higher for the new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92995

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2356
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,167
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X3 will be used to report 100% of the procedures previously reported with 92995. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92995

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92925 Tracking Number N4 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: ZZZ RUC Recommended RVU: **5.00**

CPT Descriptor: Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old male with diffuse peripheral vascular disease presents with chronic stable angina refractory to medical therapy. Stress testing shows inferior ischemia at a low level of cardiac stress. Coronary arteriography demonstrates heavily calcified coronary arteries. The left anterior descending and circumflex coronary arteries are relatively free of occlusive disease but the right coronary artery has a long heavily calcified lesion which is 50% stenotic throughout and 80% stenotic at the worst point. The posterior descending artery has a long heavily calcified lesion which is 50% stenotic throughout and 80% stenotic at the worst point. The patient is transferred to a PCI center for percutaneous coronary rotational atherectomy on the following day. The result after rotational atherectomy and angioplasty is "stent-like", and passage of a stent would be difficult due to proximal calcification and tortuosity, so stenting is not performed. The first lesion has been treated. Now an additional lesion is to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The indwelling guide catheter from the first coronary intervention is removed over a guide wire. A new guide is selected to engage the second vessel. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional

guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. The coronary guide wire is then removed through the balloon lumen and replaced with a wire specifically designed for rotational atherectomy. The balloon is removed over the wire. Balloon position is confirmed by angiography.
An appropriate sized rotational atherectomy burr is selected and the rotational atherectomy system is assembled and attached to a Rotablator Console. A Rotablator Foot Pedal is positioned under the table. The burr delivery unit is loaded with extreme care over the rotablator wire as the latter is very susceptible to kinking. If kinked the wire must be removed from the coronary and the entire process to this point is redone. Rotaflush is administered as a continuous infusion to prevent no-reflow. The burr is activated outside the body to test the rotational speed and the console is used to adjust the speed to a proper level.
The burr is advanced over the rotablator wire to the coronary artery proximal to the lesion. This typically requires carefully coordinated pulling of the wire during burr advancement to overcome resistance. The burr is adjusted to remove tension from the system. The device is activated to test the rotational speed in the body and adjusted as needed. Careful monitoring of the rhythm and blood pressure is performed as bradycardia and hypotension frequently occur. Once the test is complete, the burr is activated and advanced in a gradual back and forth motion to ablate calcific plaque. Typically the patient develops chest pain and/or electrocardiographic changes during these “runs”, which are kept short to avoid severe hypotension, bradycardia and even heart block. Angiography is performed in between runs to assess coronary flow and to ensure no dissection or perforation. The operator must wait up to several minutes between runs to allow resolution of ischemia. Multiple runs are performed with the burr until it is able to progress through the resistant lesion. Polishing runs are then performed. The burr is exchanged out over the wire. A larger burr is then selected to enlarge the lumen more optimally. The same procedure is then performed with the larger burr. After several progressively larger burrs and successful enlargement of the lumen, balloon angioplasty is typically performed to smooth out irregularities and seal any atheromatous flaps up against the vessel wall to try to prevent abrupt vessel closure.

An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. Once an adequate expansion is achieved, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow. The coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD		
Specialty(s):	ACC, SCAI		
CPT Code:	92925		
Sample Size: 418	**Resp N:** 71	**Response:** 16.9 %	
Sample Type: Random	**Additional Sample Information:** random+panel of several committees		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	14.00	200.00
Survey RVW:	3.20	5.00	**6.00**	7.75	0.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	240.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	92925	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37234	ZZZ	5.50	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13133	ZZZ	2.19	**RUC Time**	10,120

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	120,570

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 43.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 92925**	**Key Reference CPT Code:** 37234	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	0.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**45.00**	**62.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.68	4.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.65	4.23
Urgency of medical decision making	4.48	3.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.94	4.55
Physical effort required	4.65	4.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.90	4.20
Outcome depends on the skill and judgment of physician	4.97	4.53
Estimated risk of malpractice suit with poor outcome	4.73	3.90

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.39	4.03
Intra-Service intensity/complexity	4.84	4.33
Post-Service intensity/complexity	4.07	3.77

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92925 is an add-on code to 92924 that will be used to report additional branch(es) of a major coronary artery. The survey was robust and was completed by physicians who have experience the service.

They key reference code is 37234, additional tibial/peroneal revascularization with stent(s) and angioplasty when performed. This is a longer, less intense service. Key reference respondents felt surveyed code 92925 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 9-21% higher for the new code.

The panel notes that it is difficult to make a time comparison of the survey to the current code, which has 88 minutes of CMS/Other time. Our research did not produce any further information for how that 88 minutes was derived.

Due to these considerations and the broader issues of rank order and new coding conventions discussed in the attached overview, the panel recommends the 25th percentile work value of 5.00 for this service. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92996

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 436
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 231
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X4 will be used to report 100% of the procedures previously reported with 92996. This rate was then applied to 2010 utilization data.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92995

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92928 Tracking Number N5 Original Specialty Recommended RVU: **10.49**
Presented Recommended RVU: **10.49**
Global Period: 000 RUC Recommended RVU: **10.49**

CPT Descriptor: Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old obese male presents with unstable angina consistent with acute coronary syndrome. Coronary arteriography demonstrates a 22 mm long hazy 80% lesion in the circumflex coronary artery. The patient is transferred to a PCI center for percutaneous coronary intervention on the following day. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. Physical examination is conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the

pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved to allow stent deployment, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow.

The patient’s ability to tolerate long term dual antiplatelet therapy and to comply with this therapy is again confirmed. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92928				
Sample Size: 418	**Resp N:** 79	**Response:** 18.8 %			
Sample Type: Random	**Additional Sample Information:** random+panel of several committees				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	75.00	**120.00**	150.00	400.00
Survey RVW:	3.00	10.49	**13.50**	15.00	30.00
Pre-Service Evaluation Time:			**47.50**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	45.00	**60.00**	71.25	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code: 92928	**Recommended Physician Work RVU: 10.49**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:	**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**5.00**	**5.00**	**0.00**
Intra-Service Time:	**71.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37231	000	15.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33973	000	9.75	**RUC Time**	128

CPT Descriptor 1 Insertion of intra-aortic balloon assist device through the ascending aorta

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 2 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 20.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 92928**	**Key Reference CPT Code:** 37231	**Source of Time RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	71.00	135.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**140.00**	**213.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.81	4.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.94	4.44
Urgency of medical decision making	4.81	3.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.94	4.56
Physical effort required	4.56	4.63
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	4.31
Outcome depends on the skill and judgment of physician	5.00	4.63
Estimated risk of malpractice suit with poor outcome	4.88	3.94

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.75	4.13
Intra-Service intensity/complexity	4.88	4.69
Post-Service intensity/complexity	4.44	3.81

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92928 will be used to report percutaneous transcatheter placement of intracoronary stent(s) in a major coronary artery or branch. It includes angioplasty when performed. The survey was robust and was completed by physicians who have experience the service. The panel reviewed the preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37231, tibial/peroneal revascularization with stent and atherectomy. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92928 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 8-24% higher for the new code.

Due to a reduction in intraservice time and a reduction in preservice time with selection of package 2b, the panel agreed compelling evidence did not exist for the median survey RVU of 13.50 which is slightly below the current RVU. The panel recommends the 25th percentile survey RVU of 10.49 for this service. This value maintains rank order in the family. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92980

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 458962
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 225,877 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 9298X5 will be used to report 70% of the procedures previously reported with 92980. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92980

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92929 Tracking Number N6 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: ZZZ RUC Recommended RVU: **4.44**

CPT Descriptor: Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old obese male presents with unstable angina consistent with acute coronary syndrome. Coronary arteriography demonstrates a 22 mm long hazy 80% lesion in the circumflex coronary artery. An additional 22 mm long hazy 80% lesion is noted in the large first obtuse marginal branch. The patient is transferred to a PCI center for percutaneous coronary intervention on the following day. The first lesion has been treated. Now an additional lesion is to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The indwelling guide catheter from the first coronary intervention is removed over a guide wire. A new guide is selected to engage the second vessel. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wire is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the

lumen is allowed to fill passively with contrast. A balloon inflation device ("indeflator") is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved to allow stent deployment, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow.

A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92929				
Sample Size:	418	**Resp N:**	80	**Response:** 19.1 %	
Sample Type:	Random	**Additional Sample Information:**	random+panel of several committees		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**50.00**	65.00	200.00
Survey RVW:	3.00	5.00	**6.00**	7.62	35.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**30.00**	52.50	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	92929	**Recommended Physician Work RVU: 4.44**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37234	ZZZ	5.50	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	1,205,750

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60512	ZZZ	4.44	**RUC Time**	2,225

CPT Descriptor 2 Parathyroid autotransplantation (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 45.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 92929**	**Key Reference CPT Code:** 37234	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	0.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**30.00**	**62.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.56	4.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.61	4.08
Urgency of medical decision making	4.53	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.83	4.39
Physical effort required	4.53	4.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.83	4.17
Outcome depends on the skill and judgment of physician	4.83	4.39
Estimated risk of malpractice suit with poor outcome	4.61	3.81

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.33	4.06
Intra-Service intensity/complexity	4.67	4.31
Post-Service intensity/complexity	4.11	3.75

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92929 is an add-on code to 92928 that will be used to report additional branch(es) of a major coronary artery. The survey was robust and was completed by physicians who have experience with the service.

They key reference code is 37232, additional tibial/peroneal revascularization angioplasty. This is a longer, less intense service. Key reference respondents felt surveyed code 92929 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 10-21% higher for the new code.

Due to these considerations and the broader issues of rank order and new coding conventions discussed in the attached overview, the panel recommends the 25th percentile work value of 5.00 for this service. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92981

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 73060
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 36,399 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X6 will be used to report 95% of the procedures previously reported with 92981. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92981

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92933 Tracking Number N7 Original Specialty Recommended RVU: **14.00**
Presented Recommended RVU: **14.00**
Global Period: 000 RUC Recommended RVU: **12.32**

CPT Descriptor: Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old male presents with progressive angina and pharmacologic stress testing showing lateral ischemia. Coronary arteriography shows 50% lesions in the left and right coronary arteries and an 80% 12 mm long left circumflex coronary artery lesion. The vessels are extremely heavily calcified. After discussion with the patient and family regarding therapeutic options, the patient requests coronary intervention which is scheduled for the next day. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. Physical examination is conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced

retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. The coronary guide wire is then removed through the balloon lumen and replaced with a wire specifically designed for rotational atherectomy. The balloon is removed over the wire. Balloon position is confirmed by angiography.

An appropriate sized rotational atherectomy burr is selected and the rotational atherectomy system is assembled and attached to a Rotablator Console. A Rotablator Foot Pedal is positioned under the table. The burr delivery unit is loaded with extreme care over the rotablator wire as the latter is very susceptible to kinking. If kinked the wire must be removed from the coronary and the entire process to this point is redone. Rotaflush is administered as a continuous infusion to prevent no-reflow. The burr is activated outside the body to test the rotational speed and the console is used to adjust the speed to a proper level.
The burr is advanced over the rotablator wire to the coronary artery proximal to the lesion. This typically requires carefully coordinated pulling of the wire during burr advancement to overcome resistance. The burr is adjusted to remove tension from the system. The device is activated to test the rotational speed in the body and adjusted as needed. Careful monitoring of the rhythm and blood pressure is performed as bradycardia and hypotension frequently occur. Once the test is complete, the burr is activated and advanced in a gradual back and forth motion to ablate calcific plaque. Typically the patient develops chest pain and/or electrocardiographic changes during these “runs”, which are kept short to avoid severe hypotension, bradycardia and even heart block. Angiography is performed in between runs to assess coronary flow and to ensure no dissection or perforation. The operator must wait up to several minutes between runs to allow resolution of ischemia. Multiple runs are performed with the burr until it is able to progress through the resistant lesion. Polishing runs are then performed. The burr is exchanged out over the wire. A larger burr is then selected to enlarge the lumen more optimally. The same procedure is then performed with the larger burr. After several progressively larger burrs and successful enlargement of the lumen, balloon angioplasty is typically performed to smooth out irregularities and seal any atheromatous flaps up against the vessel wall to try to prevent abrupt vessel closure.

The vessel over the course of the atherectomy procedure is irregular, hazy, with slightly impaired flow, and there is concern for dissection. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. Often the stents will not pass through the calcific vessel and additional dilation with balloon angioplasty is required. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres

and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. Once an adequate expansion is achieved, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow.

Now a stent can be passed through the vessel to the target lesion. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92933				
Sample Size:	418	**Resp N:**	73	**Response:** 17.4 %	
Sample Type:	Random	**Additional Sample Information:**	random+panel of several committees		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**10.00**	20.00	200.00
Survey RVW:	3.00	14.00	**15.50**	17.00	40.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	60.00	**85.00**	90.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	92933	**Recommended Physician Work RVU: 12.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**85.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37231	000	15.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 43.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 92933**	**Key Reference CPT Code:** 37231	**Source of Time RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	85.00	135.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**154.00**	**213.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.66	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.75	4.22
Urgency of medical decision making	4.53	3.88
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.91	4.47
Physical effort required	4.66	4.31
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.88	4.19
Outcome depends on the skill and judgment of physician	4.91	4.38
Estimated risk of malpractice suit with poor outcome	4.72	3.91

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.42	4.06
Intra-Service intensity/complexity	4.88	4.43
Post-Service intensity/complexity	4.19	3.84

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92933 will be used to report percutaneous transcatheter placement of intracoronary stent(s) in a major coronary artery or branch. It includes both angioplasty and atherectomy when performed. The survey was robust and was completed by physicians who have experience with the service. The panel reviewed the preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37231, tibial/peroneal revascularization with stent and atherectomy. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92933 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 10-21% higher for the new code.

Due to a reduction in intraservice time and a reduction in preservice time with selection of package 2b, the panel agreed compelling evidence did not exist for the median survey RVU of 15.50 which is slightly below the current RVU. The panel recommends the 25th percentile survey RVU of 14.00 for this service. This value maintains rank order in the family. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92980

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 19670
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,680
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 9298X7 will be used to report 3% of the procedures previously reported with 92980. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92980

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92934 Tracking Number N8 Original Specialty Recommended RVU: **5.50**
Presented Recommended RVU: **5.50**
Global Period: ZZZ RUC Recommended RVU: **5.50**

CPT Descriptor: Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old male presents with progressive angina and pharmacologic stress testing showing lateral ischemia. Coronary arteriography shows 50% lesions in the left and right coronary arteries and an 80% 12 mm long left circumflex coronary artery lesion. An additional 12 mm long 80% lesion is noted in the large first obtuse marginal branch. The vessels are extremely heavily calcified. After discussion with the patient and family regarding therapeutic options, the patient requests coronary intervention which is scheduled for the next day. The first lesion has been treated. Now an additional lesion is to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 97%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The indwelling guide catheter from the first coronary intervention is removed over a guide wire. A new guide is selected to engage the second vessel. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple

coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. The coronary guide wire is then removed through the balloon lumen and replaced with a wire specifically designed for rotational atherectomy. The balloon is removed over the wire. Balloon position is confirmed by angiography.
An appropriate sized rotational atherectomy burr is selected and the rotational atherectomy system is assembled and attached to a Rotablator Console. A Rotablator Foot Pedal is positioned under the table. The burr delivery unit is loaded with extreme care over the rotablator wire as the latter is very susceptible to kinking. If kinked the wire must be removed from the coronary and the entire process to this point is redone. Rotaflush is administered as a continuous infusion to prevent no-reflow. The burr is activated outside the body to test the rotational speed and the console is used to adjust the speed to a proper level.
The burr is advanced over the rotablator wire to the coronary artery proximal to the lesion. This typically requires carefully coordinated pulling of the wire during burr advancement to overcome resistance. The burr is adjusted to remove tension from the system. The device is activated to test the rotational speed in the body and adjusted as needed. Careful monitoring of the rhythm and blood pressure is performed as bradycardia and hypotension frequently occur. Once the test is complete, the burr is activated and advanced in a gradual back and forth motion to ablate calcific plaque. Typically the patient develops chest pain and/or electrocardiographic changes during these “runs”, which are kept short to avoid severe hypotension, bradycardia and even heart block. Angiography is performed in between runs to assess coronary flow and to ensure no dissection or perforation. The operator must wait up to several minutes between runs to allow resolution of ischemia. Multiple runs are performed with the burr until it is able to progress through the resistant lesion. Polishing runs are then performed. The burr is exchanged out over the wire. A larger burr is then selected to enlarge the lumen more optimally. The same procedure is then performed with the larger burr. After several progressively larger burrs and successful enlargement of the lumen, balloon angioplasty is typically performed to smooth out irregularities and seal any atheromatous flaps up against the vessel wall to try to prevent abrupt vessel closure.

The vessel over the course of the atherectomy procedure is irregular, hazy, with slightly impaired flow, and there is concern for dissection. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. Often the stents will not pass through the calcific vessel and additional dilation with balloon angioplasty is required. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. Once an adequate expansion is achieved, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow.

Now a stent can be passed through the vessel to the target lesion. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no

immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92934				
Sample Size:	418	**Resp N:**	73	**Response:** 17.4 %	
Sample Type:	Random	**Additional Sample Information:**	random+panel of several committees		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.25	**5.00**	15.00	200.00
Survey RVW:	3.28	5.50	**6.50**	9.00	45.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	65.00	150.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	92934	**Recommended Physician Work RVU: 5.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37234	ZZZ	5.50	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	1,205,750

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60512	ZZZ	4.44	**RUC Time**	2,225

CPT Descriptor 2 Parathyroid autotransplantation (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 32.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 92934**	**Key Reference CPT Code:** 37234	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	0.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**45.00**	**62.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.68	4.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.70	4.22
Urgency of medical decision making	4.55	3.96
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.91	4.65
Physical effort required	4.65	4.48
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.83	4.22
Outcome depends on the skill and judgment of physician	4.87	4.65
Estimated risk of malpractice suit with poor outcome	4.65	3.96

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.43	4.13
Intra-Service intensity/complexity	4.91	4.57
Post-Service intensity/complexity	4.26	3.91

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92934 is an add-on code to 92933 that will be used to report additional branch(es) of a major coronary artery. The survey was robust and was completed by physicians who have experience with the service.

The key reference code is 37234, additional tibial/peroneal revascularization with stent(s) and angioplasty when performed. This is a longer, less intense service. Key reference respondents felt surveyed code 92934 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 5-17% higher for the new code.

Due to these considerations and the broader issues of rank order and new coding conventions discussed in the attached overview, the panel recommends the 25th percentile work value of 5.50 for this service. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92981

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 770
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 383
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X8 will be used to report 1% of the procedures previously reported with 92981. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92981

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92937 Tracking Number N9 Original Specialty Recommended RVU: **11.00**
Presented Recommended RVU: **11.00**
Global Period: 000 RUC Recommended RVU: **10.49**

CPT Descriptor: Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 79-year-old female who had bypass surgery 10 years ago presents with unstable angina consistent with an acute coronary syndrome. Coronary arteriography demonstrates that the culprit is a saphenous vein graft to a large left circumflex coronary artery. The vein graft is diffusely diseased and has subtotal occlusion by a 3 mm long thrombus. The patient is transferred to a PCI center for percutaneous coronary intervention on the following day. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. Physical examination is conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire

through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a bypass graft. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the bypass graft and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. A proximal or distal protection device is then advanced down the graft over the coronary guidewire to capture embolic debris and help prevent no-relfow. The device is carefully positioned to avoid vessel disruption and to avoid interference with intervention at the target lesion. Microvascular vasodilators are administered through the graft to help prevent no-relfow. Multiple injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

The patient’s ability to tolerate long term dual antiplatelet therapy and to comply with this therapy is again confirmed. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. As the lesion has generally not been predilated (so as to avoid embolization) positioning of the stent across the lesion often precipitates severe ischemia requiring therapy. If the stent cannot be advanced across the lesion, then the stent is removed, the lesion is predilated with angioplasty, and the stent is repositioned. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. There is no-reflow characterized by severe ischemia, slow flow down the vessel and electrocardiographic changes. Microvascular vasodilators are administered again and if there is no resolution an aspiration catheter is advanced down into the graft and debris is aspirated to restore flow. Once adequate flow is restored, assessment for the need for further balloon expansion is performed. If needed an appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device (“indeflator”) is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. If the result is acceptable, the proximal or distal protection device is then removed. Often the removal catheter must be manipulated by multiple passes to cross through the stents to reach the protection device in the case of a distal protection device. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92937				
Sample Size:	356	**Resp N:** 66	**Response:** 18.5 %		
Sample Type:	Random	**Additional Sample Information:** random+panel of several committees			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	13.50	**25.00**	67.50	300.00
Survey RVW:	8.00	11.00	**14.50**	16.00	23.10
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	60.00	**60.00**	90.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	92937	**Recommended Physician Work RVU: 10.49**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37231	000	15.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 19.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 92937**	**Key Reference CPT Code:** 37231	**Source of Time RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	60.00	135.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**129.00**	**213.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.54	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.54	4.00
Urgency of medical decision making	4.38	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.77	4.50
Physical effort required	4.23	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.85	3.77
Outcome depends on the skill and judgment of physician	4.85	4.08
Estimated risk of malpractice suit with poor outcome	4.62	3.62

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.31	3.46
Intra-Service intensity/complexity	4.67	4.00
Post-Service intensity/complexity	3.58	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92937 will be used to report percutaneous coronary revascularization of or through a coronary artery bypass graft. It includes any combination of stent(s), angioplasty, and/or atherectomy. The code also includes use of distal protection when performed. The survey was robust and was completed by physicians who have experience the service. The panel

reviewed the preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37231, tibial/peroneal revascularization with stent and atherectomy. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92937 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 6-35% higher for the new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 32784
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
16,134 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. We estimate 9298X9 will be used to report 5% of the procedures previously reported with 92980. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92980

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92938 Tracking Number N10 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: ZZZ RUC Recommended RVU: **6.00**

CPT Descriptor: Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 79-year-old female who had bypass surgery 10 years ago presents with unstable angina consistent with an acute coronary syndrome. Coronary arteriography demonstrates that the culprit is a saphenous vein graft to a large left circumflex coronary artery. The vein graft is diffusely diseased and has subtotal occlusion by a 3 mm long thrombus. The subtended left circumflex coronary artery gives off a large obtuse marginal branch with a 90% hazy lesion that is 20 mm long. The patient is transferred to a PCI center for percutaneous coronary intervention on the following day. The first lesion has been treated. Now an additional lesion is to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 98%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenosis.

A coronary guide wire is manipulated from its initial position and across the target lesion. This may require entirely removing the wire and re-shaping the tip, or starting with a new wire and passing it through the graft. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. If appropriate, a proximal or distal protection device is then advanced down the graft over the coronary guidewire to capture embolic debris and help prevent no-reflow. The device is carefully positioned to avoid vessel disruption and to avoid interference with intervention at the target lesion. Microvascular vasodilators are administered through the graft to help prevent no-relfow. Multiple injections

are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. As the lesion has generally not been predilated (so as to avoid embolization) positioning of the stent across the lesion often precipitates severe ischemia requiring therapy. If the stent cannot be advanced across the lesion, then the stent is removed, the lesion is predilated with angioplasty, and the stent is repositioned. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. There is no-reflow characterized by severe ischemia, slow flow down the vessel and electrocardiographic changes. Microvascular vasodilators are administered again and if there is no resolution an aspiration catheter is advanced down into the graft and debris is aspirated to restore flow. Once adequate flow is restored, assessment for the need for further balloon expansion is performed. If needed an appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device ("indeflator") is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. If the result is acceptable, the proximal or distal protection device is then removed. Often the removal catheter must be manipulated by multiple passes to cross through the stents to reach the protection device in the case of a distal protection device. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, ASE				
CPT Code:	92938				
Sample Size:	356	**Resp N:** 67	**Response:** 18.8 %		
Sample Type:	Random	**Additional Sample Information:** random+panel of several committees			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	50.00	250.00
Survey RVW:	1.00	5.00	**6.00**	7.00	24.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**60.00**	77.50	150.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	92938	**Recommended Physician Work RVU: 6.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37234	ZZZ	5.50	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35600	ZZZ	4.94	**RUC Time**	2,872

CPT Descriptor 1 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22534	ZZZ	5.99	**RUC Time**	917

CPT Descriptor 2 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 29 **% of respondents:** 43.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 92938**	**Key Reference CPT Code:** 37234	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	0.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**60.00**	**62.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.24	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.48	3.86
Urgency of medical decision making	4.41	3.34
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.76	4.28
Physical effort required	4.24	4.10
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.76	3.90
Outcome depends on the skill and judgment of physician	4.76	4.29
Estimated risk of malpractice suit with poor outcome	4.59	3.66

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.07	3.45
Intra-Service intensity/complexity	4.66	4.28
Post-Service intensity/complexity	3.83	3.31

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92938 is an add-on code to 92937 that will be used to report additional branch(es) that was subtended by the bypass graft. The survey was robust and was completed by physicians who have experience with the service.

The key reference code is 37234, additional tibial/peroneal revascularization with stent(s) and angioplasty when performed. This code has identical intraservice time of 60 minutes. Key reference respondents felt surveyed code 92938 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 11-32% higher for the new code.

The panel recommends the 25th percentile survey RVU of 5.00 for this newly defined service. This value aligns closely with the key reference code of 37234 which has a work RVU of 5.50. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92981

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3846
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,916
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X10 will be used to report 5% of the procedures previously reported with 92981. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92981

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92941 Tracking Number N11 Original Specialty Recommended RVU: **14.50**
Presented Recommended RVU: **12.32**
Global Period: 000 RUC Recommended RVU: **12.32**

CPT Descriptor: Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male calls 911 for sudden onset of crushing substernal chest pain. Pre-hospital 12 lead electrocardiography in the ambulance demonstrates acute anterior myocardial infarction with ST elevation in leads V2-V5. The heart attack alert system is activated. The emergency medical personnel bypass the emergency department and take the patient directly to the cardiac catheterization laboratory, arriving within 50 minutes of symptom onset. After rapid assessment, immediate coronary angiography is performed (reported separately), demonstrating 100% occlusion by a large thrombus in the middle segment of the left anterior descending artery. The patient demonstrates runs of non-sustained ventricular tachycardia. Percutaneous coronary intervention is planned immediately with the goal of achieving first medical contact-to-balloon time of under 90 minutes. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 99%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are rapidly reviewed. Physical examination is rapidly conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is quickly reviewed with the patient. The risks and benefits of the procedure are rapidly presented, as well as the alternatives. Informed consent is obtained. In an emergent fashion, hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is rushed to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" is rapidly performed which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is rapidly obtained, typically through the femoral artery or radial artery. Often the pulse is rapid and thread in the setting of hypotension and

access is frequently difficult as a result. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access.

After diagnostic coronary angiography to identify the culprit lesion (reported separately) an appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views and often requires additional guidewires if the first wires is not successful. Wire position across the lesion is confirmed angiographically. The wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Brief angiography confirms intraluminal position of the guidewire. There is no flow down the vessel and the patient is typically in severe pain. An appropriate aspiration catheter is selected and rapidly advanced to the occluded vessel and thrombus is aspirated. Multiple rounds of intracoronary microvascular vasodilators are administered. Frequently reperfusion arrhythmias occur requiring additional pharmacologic management. Hypotension frequently requires titration of pressor agents. Antegrade coronary flow is restored, but there is globular thrombus superimposed on a critical residual lesion. Intracoronary antiplatelet agents are infused to help resolve the thrombus.

An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device ("indeflator") is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. Typically the patient develops chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved to allow stent deployment, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow.

The patient's ability to tolerate long term dual antiplatelet therapy and to comply with this therapy is again confirmed. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. This may require placing additional coronary guide wires down the vessel to allow the stent to pass. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. Frequently there is some degree of no-reflow requiring additional microvascular vasodilators to resolve. Frequently there is evidence of thrombotic embolization to distal vessels beyond the original lesion. This requires additional balloon dilation and aspiration thrombectomy at the site of the thrombus to resolve. Frequently there is ongoing hemodynamic instability and electrical instability requiring additional pharmacologic therapy. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators.

Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92941				
Sample Size:	356	**Resp N:** 67	**Response:** 18.8 %		
Sample Type:	Random	**Additional Sample Information:** random+panel of several committees			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**30.00**	47.50	230.00
Survey RVW:	9.00	14.50	**16.00**	20.00	30.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	60.00	**70.00**	90.00	240.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	92941	**Recommended Physician Work RVU: 12.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**70.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37231	000	15.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 31.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 92941**	**Key Reference CPT Code:** 37231	**Source of Time RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	70.00	135.00	
Median Immediate Post-service Time	40.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**149.00**	**213.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.81	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.76	4.05
Urgency of medical decision making	4.95	3.43
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.90	4.48
Physical effort required	4.62	4.24
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.95	3.95
Outcome depends on the skill and judgment of physician	4.95	4.33
Estimated risk of malpractice suit with poor outcome	4.86	3.81

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.76	3.95
Intra-Service intensity/complexity	4.95	4.24
Post-Service intensity/complexity	4.62	3.57

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92941 will be used to report percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft. It includes any combination of stent(s), angioplasty, and/or atherectomy. The code also includes aspiration thrombectomy when performed. The survey was

robust and was completed by physicians who have experience with the service. The panel reviewed the preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37231, tibial/peroneal revascularization with stent and atherectomy. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92941 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 9-44% higher for the new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92980

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 163916
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 80,671 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty.

Please explain the rationale for this estimate. We estimate 9298X11 will be used to report 25% of the procedures previously reported with 92980. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92980

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92943 Tracking Number N12 Original Specialty Recommended RVU: **14.00**
Presented Recommended RVU: **12.32**
Global Period: 000 RUC Recommended RVU: **12.32**

CPT Descriptor: Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old female presents with 6 months of exertional angina. Coronary angiography shows 100% left circumflex coronary stenosis. The lesion is on a bend in the circumflex coronary artery with focal calcification at the site and has antegrade bridging collaterals to the distal vessel, consistent with a chronic total occlusion. After a 2-week trial of 2 anti-anginal agents, the patient is not satisfied with her quality of life and requests coronary intervention. This is the first lesion in this coronary territory to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. Physical examination is conducted. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Hair is removed from the potential access sites. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The patient's information is loaded in the hemodynamic monitoring equipment in order to retain the data from the upcoming study.

Description of Intra-Service Work: A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced

retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to attempt to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views. Typically, crossing of the total occlusion with generic guide wires is unsuccessful. Typically, the operator uses additional guidewires progressing to increasingly stiff, guidewires in order to puncture through the chronic total occlusion, or more lubricious or tapered tip wires are used to engage and cross a microchannel. Wire position across the lesion is confirmed angiographically. Frequently, the wire is extraluminal and left in position while additional wires are used to reattempt crossing of the total occlusion. If crossing of the total occlusion is eventually achieved successfully, and the wire is intraluminal distally, the wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device ("indeflator") is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Often no balloon will cross the rigid total occlusion. Specialty devices may be employed to screw or "Dotter" through the rigid total occlusion. Rotational atherectomy may be attempted to ablate the rigid material at the total occlusion site. If crossing is eventually achieved, an angioplasty balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. The patient may develop chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved to allow stent deployment, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow. Frequently, there is evidence of dissection from the recanalization of the total occlusion and frequently additional lesions are now evident in the vessel. In the event of a vessel perforation, emergent echocardiogram may be requested and pericardiocentesis, volume resuscitation, and vasopressors may be required to stabilize the patients.

The patient's ability to tolerate long term dual antiplatelet therapy and to comply with this therapy is again confirmed. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. Frequently, the stent will not cross due to rigidity of the lesion. This may require placing additional coronary guide wires down the vessel, placement of a more aggressive guiding catheter, or more balloon dilation to allow the stent to pass. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased/dissected segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work: Films and hemodynamics are reviewed and a formal report is generated. The patient, family and the referring physician are notified of the results. A plan of management is developed and discussed with the patient and family. Additional antiplatelet and antithrombin therapy is administered as necessary. The patient is admitted to ensure no bleeding, to monitor for abrupt vessel closure, and for continued therapy of ischemic heart disease.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD				
Specialty(s):	ACC, SCAI				
CPT Code:	92943				
Sample Size:	356	**Resp N:** 65	**Response:** 18.2 %		
Sample Type:	Random	**Additional Sample Information:** random+panel of several committees			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	20.00	150.00
Survey RVW:	4.25	14.00	**15.00**	19.00	27.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	80.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	92943	**Recommended Physician Work RVU: 12.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37231	000	15.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 29.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 92943**	**Key Reference CPT Code:** 37231	**Source of Time** **RUC Time**
Median Pre-Service Time	39.00	48.00	
Median Intra-Service Time	90.00	135.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**159.00**	**213.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.42	4.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.53	4.00
Urgency of medical decision making	4.00	3.61
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	4.39
Physical effort required	4.95	4.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.84	4.11
Outcome depends on the skill and judgment of physician	4.95	4.41
Estimated risk of malpractice suit with poor outcome	4.78	4.06

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.37	3.83
Intra-Service intensity/complexity	4.95	4.39
Post-Service intensity/complexity	3.95	3.56

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92943 will be used to report percutaneous transluminal revascularization of a chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft. It includes any combination of stent(s), angioplasty, and/or atherectomy. The survey was robust and was completed by physicians who have experience with the service. The panel reviewed the preservice time and selected package 2b for a straightforward procedure on a difficult patient with moderate sedation in a facility.

The key reference service is 37231, tibial/peroneal revascularization with stent and atherectomy. While procedurally similar, this is a longer, less intense service. Key reference respondents felt surveyed code 92943 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 9-18% higher for the new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92980

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 39340
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 19,361 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 9298X12 will be used to report 6% of the procedures previously reported with 92980. This rate was then applied to 2010 utilization data.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92980

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92944 Tracking Number N13 Original Specialty Recommended RVU: **6.00**
Presented Recommended RVU: **6.00**
Global Period: ZZZ RUC Recommended RVU: **6.00**

CPT Descriptor: Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male presents with a 3 year history of stable angina. Stress testing shows inferior ischemia but no myocardial infarction. Coronary arteriography demonstrates 100% mid-right coronary occlusion with left-to-right collaterals to the distal vessel. The occluded segment is about 20 mm long and appears straight with focal calcification at the lesion site consistent with a chronic total occlusion. In the posterior descending, there is an additional occluded segment that is about 20 mm long and appears straight with focal calcification at the lesion site consistent with a chronic total occlusion. After a 2-week trial of 2 anti-anginal agents, the patient is not satisfied with his quality of life and requests coronary intervention. The first lesion has been treated. Now an additional lesion is to be treated.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: A “Time Out” occurs during which confirmation of critical information is ensured, such as the patient’s identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered and adequate conscious sedation monitoring is verified. Percutaneous arterial access is obtained, typically through the femoral artery or radial artery. A thin-walled needle is inserted percutaneously into the peripheral artery, through which a flexible guide wire is inserted. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. Intra-arterial vasodilators are administered to prevent arterial spasm for radial artery access. An appropriate guiding catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance throughout the procedure. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. The guide is aspirated to remove any air, atheroma, or thrombus. Pressure is measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery. Typically the guide must be manipulated to avoid aortic atheroma and adjusted substantially to engage the artery based on the anatomy of the

aorta. The arterial pressure and waveform are then checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Frequently, several guide catheters are required to achieve a safe catheter engagement of the artery. Test contrast injections under fluoroscopy are performed to check catheter position.

Appropriate antiplatelet therapy pretreatment is confirmed, and additional antiplatelet therapy is administered as needed. Direct thrombin inhibitors or heparin is administered for anticoagulation. Therapeutic anticoagulation is confirmed by drawing blood from the guide and testing an Activated Clotting Time (ACT). Additional anticoagulation is administered as needed to achieve a therapeutic ACT. Intracoronary vasodilators are administered. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses.

A coronary guide wire is then manipulated through the guide and down the coronary artery and carefully used to attempt to cross the target lesion. Typically, this requires manipulation of the wire in several angiographic views. Typically, crossing of the total occlusion with generic guide wires is unsuccessful. Typically, the operator uses additional guidewires progressing to increasingly stiff, guidewires in order to puncture through the chronic total occlusion, or more lubricious or tapered tip wires are used to engage and cross a microchannel. Wire position across the lesion is confirmed angiographically. Frequently, the wire is extraluminal and left in position while additional wires are used to reattempt crossing of the total occlusion. If crossing of the total occlusion is eventually achieved successfully, and the wire is intraluminal distally, the wire is adjusted as needed to ensure it is not lodged in a small distal vessel that might result in perforation or dissection. Multiple coronary injections are performed, each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess the stenoses. An appropriate sized balloon is selected. The balloon is deaired and the lumen is allowed to fill passively with contrast. A balloon inflation device ("indeflator") is prepared and filled with dilute contrast. The balloon is advanced over the coronary guidewire to the lesion. Often no balloon will cross the rigid total occlusion. Specialty devices may be employed to screw or "Dotter" through the rigid total occlusion. Rotational atherectomy may be attempted to ablate the rigid material at the total occlusion site. If crossing is eventually achieved, an angioplasty balloon position is confirmed by angiography. The balloon is inflated gradually, observing for clinical and angiographic signs of ischemia, and watching for balloon deformation and appropriate balloon expansion. The patient may develop chest pain and/or electrocardiographic changes that limit the duration of balloon inflation and the balloon is quickly deflated. The balloon is reinflated several times to progressively higher atmospheres and for longer periods of time up to several minutes. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. The lesion is not fully expanded and the angioplasty procedure is repeated multiple times with progressively larger balloons. Once an adequate expansion is achieved to allow stent deployment, the balloon is again exchanged out of the coronary artery into the guide. Completion angiography is performed after repeat administration of intracoronary vasodilators. Inspection of the images is performed for signs of vessel dissection, perforation or impaired coronary flow. Frequently, there is evidence of dissection from the recanalization of the total occlusion and frequently additional lesions are now evident in the vessel. In the event of a vessel perforation, emergent echocardiogram may be requested and pericardiocentesis, volume resuscitation, and vasopressors may be required to stabilize the patients.

The patient's ability to tolerate long term dual antiplatelet therapy and to comply with this therapy is again confirmed. A stent of appropriate diameter and length is selected. The stent is advanced over the wire to the target lesion and carefully positioned. Frequently, the stent will not cross due to rigidity of the lesion. This may require placing additional coronary guide wires down the vessel, placement of a more aggressive guiding catheter, or more balloon dilation to allow the stent to pass. The stent is deployed at high pressure. The original stent frequently does not cover the entire diseased/dissected segment and additional stents are then placed as needed using the same techniques. Next a high pressure non-compliant balloon is advanced over the coronary guidewire into the stented segment and this is inflated at high pressure to ensure stent expansion. Frequently more than one balloon of different sizes is required. The balloon is then exchanged back over the guidewire into the guide. Intracoronary vasodilators are again administered. Angiography is performed in multiple views. If the result is acceptable, the coronary wire is then withdrawn back into the guide. Completion angiography is again performed after repeat administration of intracoronary vasodilators. Inspection of the images is again performed for signs of vessel dissection, perforation or impaired coronary flow. The guide catheter is disengaged from the coronary ostium and then removed over a guide wire from the body. Anticoagulation infusions are stopped.

Angiography of the access site is often performed through the access sheath to assess for any complications and suitability for a percutaneous closure device. The catheter and sheath are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision. Observation of the site is performed to ensure no immediate bleeding if a vascular closure device is deployed. Manual pressure is required for a short time to achieve

complete hemostasis. If manual pressure is used, typically the sheath is sewn in for subsequent removal once the ACT level falls to a safe level.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Richard Wright, MD; Cliff Kavinsky, MD		
Specialty(s):	ACC, SCAI		
CPT Code:	92944		
Sample Size:	356	**Resp N:** 64	**Response:** 17.9 %
Sample Type:	Random	**Additional Sample Information:**	random+panel of several committees

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**10.00**	20.00	250.00
Survey RVW:	3.50	6.00	**7.00**	11.38	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	45.00	**60.00**	120.00	200.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	92944	**Recommended Physician Work RVU: 6.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37234	ZZZ	5.50	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22534	ZZZ	5.99	**RUC Time**	917

CPT Descriptor 1 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	ZZZ	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 43.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 92944**	**Key Reference CPT Code:** 37234	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	0.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**60.00**	**62.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.57	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.39	4.00
Urgency of medical decision making	3.86	3.52
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.86	4.26
Physical effort required	4.75	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.75	4.00
Outcome depends on the skill and judgment of physician	4.89	4.37
Estimated risk of malpractice suit with poor outcome	4.54	3.78

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.14	3.67
Intra-Service intensity/complexity	4.96	4.19
Post-Service intensity/complexity	3.93	3.52

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 92944 is an add-on code to 92943 that will be used to report ach additional coronary artery, coronary artery branch, or bypass graft. The survey was robust and was completed by physicians who have experience with the service.

The key reference code is 37234, additional tibial/peroneal revascularization with stent(s) and angioplasty when performed. This code has identical intraservice time of 60 minutes. Key reference respondents felt surveyed code 92944 entails significantly more mental effort, technical skill, and psychological stress than the reference code. These comparisons were 10-20% higher for the new code.

The panel recommends the 25th percentile survey RVU of 6.00 for this newly defined service. This value maintains rank order with other add-on codes in the family and reflects the increased intraservice time indicated by respondents in comparison to other add-on codes in the family that had code precursors. It reflects the increased intensity of this code over 92938. It also aligns closely with the less intense key reference code, 37234, which has a work RVU of 5.50. Please see the attached summary for a more comprehensive analysis of the PCI family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92981

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1538
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This national estimate is predicated on the Medicare popuation estimate below. We estimate one half of the total utilization will be in the Medicare population.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 766
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We predict 9298X13 will be used to report 2% of the procedures previously reported with 92981. This rate was then applied to 2010 utilization data.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92981

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
20						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
21	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
22	**REF**	**37225**	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	**18**	**0.087**			**12.00**			**196**	**40**	**3**	**5**			**118**			**30**
23	**CURRENT**	**92982**	Percutaneous transluminal coronary balloon angioplasty; single vessel		**0.114**			**10.96**			**179**	**38**		**25**			**80**			**36**
24	**SVY**	**92920**	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	**79**	**0.150**	**3.00**	**9.25**	**11.00**	**13.40**	**21.55**	**160**	**45**	**10**	**15**	**20**	**45**	**60**	**60**	**120**	**30**
25	**REC**				**0.125**			**9.00**			**129**	**33**	**1**	**5**			**60**			**30**
26																				
27						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
28	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
29	**REF**	**37232**	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	**24**	**0.099**			**4.00**			**42**	**1**					**40**			**1**
30	**CURRENT**	**92984**	Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)		**0.036**			**2.97**			**83**						**83**			
31	**SVY**	**92921**	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	**80**	**0.167**	**2.10**	**4.00**	**5.00**	**6.50**	**25.00**	**30**				**15**	**25**	**30**	**45**	**250**	
32	**REC**				**0.133**			**4.00**			**30**						**30**			
33																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
34								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
35	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
36	**REF**	**37229**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	**21**	**0.103**			**14.05**			**198**	**40**	**3**	**5**			**120**			**30**
37	**CURRENT**	**92995**	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel		**0.061**			**12.07**			**275**	**60**					**155**			**60**
38	**SVY**	**92924**	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	**73**	**0.163**	**3.40**	**12.00**	**14.50**	**15.50**	**30.00**	**185**	**50**	**15**	**15**	**20**	**60**	**75**	**90**	**120**	**30**
39	**REC**				**0.127**			**11.00**			**144**	**33**	**1**	**5**			**75**			**30**
40																				
41								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
42	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
43	**REF**	**37234**	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	**31**	**0.091**			**5.50**			**62**	**1**					**60**			**1**
44	**CURRENT**	**92996**	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)		**0.037**			**3.26**			**88**						**88**			
45	**SVY**	**92925**	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	**71**	**0.133**	**3.20**	**5.00**	**6.00**	**7.75**	**30.00**	**45**				**15**	**30**	**45**	**60**	**240**	
46	**REC**				**0.111**			**5.00**			**45**						**45**			
47																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
48								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
49	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
50	**REF**	**37231**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	**16**	**0.099**			**15.00**			**213**	**40**	**3**	**5**			**135**			**30**
51	**CURRENT**	**92980**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel		**0.104**			**14.82**			**225**	**45**					**120**			**60**
52	**SVY**	**92928**	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	**80**	**0.188**	**3.00**	**10.49**	**13.50**	**15.00**	**30.00**	**168**	**47.5**	**15**	**15**	**20**	**45**	**60**	**71**	**120**	**30**
53	**REC**				**0.127**			**10.49**			**140**	**33**	**1**	**5**			**71**			**30**
54																				
55								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
56	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
57	**REF**	**37234**	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	**36**	**0.091**			**5.50**			**62**	**1**					**60**			**1**
58	**CURRENT**	**92981**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)		**0.069**			**4.16**			**60**						**60**			
59	**SVY**	**92929**	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	**80**	**0.200**	**3.00**	**5.00**	**6.00**	**7.63**	**35.00**	**30**				**15**	**30**	**30**	**53**	**120**	
60	**REC**				**0.148**			**4.44**			**30**						**30**			
61																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
62								RVW			Total	PRE-TIME					INTRA-TIME			IMMD
63	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
64	**REF**	**37231**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	**32**	**0.099**			**15.00**			**213**	**40**	**3**	**5**			**135**			**30**
65	**CURRENT**	**92980**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel		**0.104**			**14.82**			**225**	**45**					**120**			**60**
66	**SVY**	**92933**	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	**73**	**0.156**	**3.00**	**14.00**	**15.50**	**17.00**	**40.00**	**195**	**50**	**15**	**15**	**30**	**60**	**85**	**90**	**180**	**30**
67	**REC**				**0.128**			**12.32**			**154**	**33**	**1**	**5**			**85**			**30**
68																				
69								RVW			Total	PRE-TIME					INTRA-TIME			IMMD
70	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
71	**REF**	**37234**	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	**24**	**0.091**			**5.50**			**62**	**1**					**60**			**1**
72	**CURRENT**	**92981**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)		**0.069**			**4.16**			**60**						**60**			
73	**SVY**	**92934**	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	**73**	**0.144**	**3.28**	**5.50**	**6.50**	**9.00**	**45.00**	**45**				**15**	**30**	**45**	**65**	**150**	
74	**REC**				**0.122**			**5.50**			**45**						**45**			
75																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
76						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
77	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
78	**REF**	**37231**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	**13**	**0.099**			**15.00**			**213**	**40**	**3**	**5**			**135**			**30**
79	**CURRENT**	**92980**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel		**0.104**			**14.82**			**225**	**45**					**120**			**60**
80	**SVY**	**92937**	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	**66**	**0.200**	**8.00**	**11.00**	**14.50**	**16.00**	**23.10**	**180**	**60**	**15**	**15**	**20**	**60**	**60**	**90**	**120**	**30**
81	**REC**				**0.150**			**10.49**			**129**	**33**	**1**	**5**			**60**			**30**
82																				
83						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
84	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
85	**REF**	**37234**	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	**29**	**0.091**			**5.50**			**62**	**1**					**60**			**1**
86	**CURRENT**	**92981**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)		**0.069**			**4.16**			**60**						**60**			
87	**SVY**	**92938**	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)	**67**	**0.100**	**1.00**	**5.00**	**6.00**	**7.00**	**24.00**	**60**				**10**	**30**	**60**	**78**	**150**	
88	**REC**				**0.100**			**6.00**			**60**						**60**			
89																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
90						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
91	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
92	**REF**	**37231**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	**21**	**0.099**			**15.00**			**213**	**40**	**3**	**5**			**135**			**30**
93	**CURRENT**	**92980**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel		**0.104**			**14.82**			**225**	**45**					**120**			**60**
94	**SVY**	**92941**	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	**67**	**0.203**	**9.00**	**14.50**	**16.00**	**20.00**	**30.00**	**160**	**20**	**15**	**15**	**30**	**60**	**70**	**90**	**240**	**40**
95	**REC**				**0.152**			**12.32**			**149**	**33**	**1**	**5**			**70**			**40**
96																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Percutaneous Coronary Intervention**																		
13	**TAB:**	**11**																		
97						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
98	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
99	**REF**	**37231**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	**19**	**0.099**			**15.00**			**213**	**40**	**3**	**5**			**135**			**30**
100	**CURRENT**	**92980**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel		**0.104**			**14.82**			**225**	**45**					**120**			**60**
101	**SVY**	**92943**	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	**65**	**0.138**	**4.25**	**14.00**	**15.00**	**19.00**	**27.00**	**215**	**65**	**15**	**15**	**30**	**80**	**90**	**120**	**180**	**30**
102	**REC**				**0.121**			**12.32**			**159**	**33**	**1**	**5**			**90**			**30**
103																				
104						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
105	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
106	**REF**	**37234**	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	**28**	**0.091**			**5.50**			**62**	**1**					**60**			**1**
107	**CURRENT**	**92981**	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)		**0.069**			**4.16**			**60**						**60**			
108	**SVY**	**92944**	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)	**64**	**0.117**	**3.50**	**6.00**	**7.00**	**11.38**	**25.00**	**60**				**20**	**45**	**60**	**120**	**200**	
109	**REC**				**0.100**			**6.00**			**60**						**60**			
110																				
111																				

Tab 10 Percutaneous Coronary Intervention

Code	Description	Rec	Rec Pre	Rec Intra	Rec Post	Rec Total	IWPUT
92920	Angioplasty	9.00	39	60	30	129	0.125
92921	Angioplasty, additional	4.00		30		30	0.133
92924	Atherectomy w/ angioplasty	11.00	39	75	30	144	0.127
92925	Atherectomy w/ angioplasty, additional	5.00		45		45	0.111
92928	Stent w/ angioplasty	10.49	39	71	30	140	0.127
92929	Stent w/ angioplasty, additional	4.44		30		30	0.148
92933	Atherectomy w/ stent w/ angioplasty	12.32	39	85	30	154	0.128
92934	Atherectomy w/ stent w/ angioplasty, additional	5.50		45		45	0.122
92937	Any revasc of CABG w/ w/out distal protection	10.49	39	60	30	129	0.150
92938	Any revasc of CABG w/ w/out distal protection, additional	6.00		60		60	0.100
92941	Any revasc of acute total/subtotal occlusion (STEMI)	12.32	26	70	40	136	0.156
92943	Any revasc of chronic total occlusion w/ w/out thrombectomy	12.32	39	90	30	159	0.121
92944	Any revasc of chronic total occlusion w/ w/out thrombectomy, additional	6.00		60		60	0.100

000 Codes (In rank order)

Code	Description	Rec	Rec Pre	Rec Intra	Rec Post	Rec Total	IWPUT
Traditional Base Codes							
92920	Angioplasty	9.00	39	60	30	129	0.125
92928	Stent w/ angioplasty	10.49	39	71	30	140	0.127
92924	Atherectomy w/ angioplasty	11.00	39	75	30	144	0.127
92933	Atherectomy w/ stent w/ angioplasty	12.32	39	85	30	154	0.128
New Patient Population Base Codes							
92937	Any revasc of CABG w/ w/out distal protection	10.49	39	60	30	129	0.150
92941	Any revasc of acute total/subtotal occlusion (STEMI)	12.32	26	70	40	136	0.156
92943	Any revasc of chronic total occlusion w/ w/out thrombectomy	12.32	39	90	30	159	0.121

ZZZ Codes (In rank order)

Code	Description	Rec	Rec Pre	Rec Intra	Rec Post	Rec Total	IWPUT
Traditional Add-on Codes							
92921	Angioplasty, additional	4.00		30		30	0.133
92929	Stent w/ angioplasty, additional	4.44		30		30	0.148
92925	Atherectomy w/ angioplasty, additional	5.00		45		45	0.111
92934	Atherectomy w/ stent w/ angioplasty, additional	5.50		45		45	0.122
New Patient Population Add-on Codes							
92938	Any revasc of CABG w/ w/out distal protection, additional	6.00		60		60	0.100
92944	Any revasc of chronic total occlusion w/ w/out thrombectomy, additional	6.00		60		60	0.100

PCI Family Rationale Summary

In the 2011 Medicare physician fee schedule final rule, CMS indicated that it desired services on the MPC list that had not been valued over the past five years be reexamined by the RUC. One of the services on this list was code 92980, used to report the placement of a coronary stent. After reviewing the code during the RUC process, the ACC and SCAI felt that the entire family of percutaneous coronary intervention (PCI) codes should be revised to reflect current practice and to reflect coding conventions established as part of the revision of lower extremity revision (LER) codes in 2010. The CPT Editorial Panel approved the creation of a set of 13 new codes in October. Codes were revised to capture the three techniques used for PCI (angioplasty, atherectomy, and stent) which can be used in various combinations depending on the patient presentation. In addition, three very different populations representing those who have had coronary artery bypass graft(s) (CABG), those having active ST-elevated myocardial infarction (STEMI) heart attacks, and those with chronic total coronary artery occlusion were separated because of the significant difference in the work and the typical patient. We feel the best way to evaluate these codes is in four separate groups: traditional base codes, traditional add-on codes, new patient population base codes, and new patient population add-on codes.

Traditional Base Codes (92920, 92924, 92928, 92933)

For the first four base codes, rank order proceeded as expected with angioplasty (92920) requiring the lowest amount of work. Stent with angioplasty (92928) is more work; atherectomy with angioplasty (92924) is yet more work; finally, stent with both angioplasty and atherectomy (92933) is the most work. Due to the reduction in intraservice time we have recommended the 25th percentile for these four codes. We note that this still produces values with relatively high intensity. However, we feel this increased intensity can validly be attributed to the broader diversity of patients in whom PCI is currently utilized, particularly those with acute coronary syndromes and in the very elderly. This trend has been documented in literature that concluded PCIs "in the last 2 decades, have evolved to include more urgent, comorbid cases, despite achieving high success rates with significantly reduced need for repeat revascularization."[1] Additionally, the variety of drugs, devices, instruments, and patient management is more complex than in the past. Finally, we feel the robust survey response further validates the recommendations we have made.

Traditional Add-on Codes (92921, 92925, 92929, 92934)

The first four add-on codes that correspond to the traditional base codes are entirely new services because of the way the codes were rewritten. PCI add-ons are currently reported per vessel so that only a single code would be reported regardless of the number of branches treated in a single vessel. These new codes could be reported for a second additional branch of a major coronary artery, as defined in the new CPT introductory language. We recommend he 25th percentile for these four codes.

New Patient Population Base Codes (92937, 92941, 92943)

These base codes describe PCI performed on newly described patient populations. In this case, they do not differentiate based on the PCI technique. These codes were created to describe a level of work that is significantly higher than the traditional PCI population and are among the most complex patients encountered by an interventional cardiologist. The rank order again proceeded as expected with PCI of CABG (92937) requiring the lowest amount of work. PCI of chronic occlusion (92943) is more work; finally, PCI of acute occlusion (STEMI) (92941) is the most work. To maintain rank order for both work RVU and IWPUT, we recommend the 25th percentile for these three codes. Additionally, we note that

[1] Venkitachalam, et al. *Circulation: Cardiovascular Interventions. 2009; 2: 6-13*

the value for PCI of a chronic occlusion is the same as that for stent with both angioplasty and atherectomy. We feel this is a good benchmark between the two groups.

New Patient Population Add-on Codes (92938, 92944)
These two add-on codes correspond to the base codes for PCI of/through CABG and chronic total occlusion, respectively. To maintain rank order for both work RVU and IWPUT, we recommend the 25th percentile for these three codes.

Utilization
The new CPT introductory language accompanying these codes defines, for coding purposes, which coronary vasculature constitutes major coronary arteries and which constitutes coronary artery branches. Based on these parameters and coding instructions, we predict utilization of the 13 new codes will result in a **12.5% RVU reduction** for the family.

The ACC, in collaboration with SCAI, maintains a registry for PCI that covers more than 75% of hospitals that provide PCI in the United States. This Cath-PCI registry has captured the number of cases in which multiple vessels are treated or multiple branches of the same vessel are treated. We used this registry data to estimate the distribution of work from the current coding system to the new coding system. Cath-PCI registry data indicate that 28% of stent PCIs involve more than one lesion. 14 stents are used per 10 stent patients, and by this reckoning, under the old coding system, 6 patients would get 1 stent (one code), 2 would get 2 stents in a major coronary artery (1 code), 1 would get a stent in major coronary artery and a in a coronary artery branch (1 code), and 1 would get a stent in 2 major coronary arteries (2 codes). Under the new system, the patient with the stent in the major coronary artery and the stent in the coronary artery branch would get 2 codes. So, out of these 10 patients, the old system would produce 11 codes (10 base codes and 1 each additional) and the new system would produce 12 codes (10 base codes and 2 add-ons). (see table below) This estimate is confirmed by the RUC database Medicare utilization data that shows for 2010, 92980 (stent) was reported 328,000 times and 92981 (each additional stent) was reported 38,000 times. We are estimating an additional 31,000 units in our budget neutrality crosswalk (attached). Despite this 8% increase in the number of units, our recommendations will result in a 12.5% overall RVU reduction due to recommendations for several services being substantially lower than current values.

10 Typical patients	Old 92980-1		New 92928-92929
Patients 1-6: 1 stent in 1 major coronary artery	92980		92928
	92980		92928
	92980		92928
	92980		92928
	92980		92928
	92980		92928
Patients 7-8: 2 stents in 1 major coronary artery	92980		92928
	92980		92928
Patient 9: 1 stent in 1 major coronary artery, 1 stent in 1 branch	92980		9598X5, 92929
Patient 10: 2 stents in 2 major coronary arteries	92980, 92981		92928 x 2

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Codes Reported Together 75% of More Screen

January 2012

Bundling EPS with Transcatheter Ablation

In February 2010, the Relativity Assessment Workgroup (RAW) identified CPT codes 93651 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination* and 93652 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia* as billed together more than 75% of the time with CPT code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording.* The specialty societies referred this issue to the CPT Editorial Panel at the October 2011 meeting and it was surveyed for the January 2012 RUC meeting.

93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry*

The RUC reviewed the survey results from 182 cardiologists who perform the service and recommend the following physician work time components: 39 minutes pre-service time, 180 minutes intra-service time and 30 minutes post-service time. The RUC discussed two issues related to the physician time for this service. First, the RUC discussed the time variation between the bundled 93653 code and the previously reported codes. It was noted that the current survey has almost 150 more survey respondents than the previous surveys. Thus, the RUC determined that these current survey data in both physician work and time are the best measure for the valuation of this service. Second, the RUC discussed the typical number of patients a practicing physician would see in a typical day. Given the large amount of time involved in these codes, the specialty society explained that two patients are typically seen by the physician per day for this service.

The RUC reviewed the robust survey data for 93653 and agreed that the survey 25th percentile of 15.00 work RVUs accurately accounts for the physician work involved in the service. To justify this value, the RUC compared the surveyed code to reference CPT code 33889 *Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral* (work RVU= 15.92) and agreed that since the reference code has greater total time, 298 minutes, compared to the surveyed code, 265 minutes, 33889 should be valued slightly higher than 93653. Finally, the RUC reviewed CPT code 50575 *Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy,*

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ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent) (work RVU= 13.96) and noted that while the two services have identical intra-service time of 180 minutes, 93653 is a more intense procedure and should be valued higher than 50575. **The RUC recommends a work RVU of 15.00 for CPT code 93653.**

93654 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3-dimensional mapping, when performed and left ventricular pacing and recording, when performed*

The RUC reviewed the survey results from 179 cardiologists who perform the service and recommend the following physician work time components: 70 minutes pre-service time, 240 minutes intra-service time and 40 minutes post-service time. The RUC discussed two issues related to the physician time for this service. First, the RUC discussed the time variation between the bundled 93654 code and the previously reported codes. It was noted that the current survey has almost 150 more survey respondents than the previous surveys. Thus, the RUC determined that these current survey data in both physician work and time are the best measure for the valuation of this service. Second, the RUC discussed the typical number of patients a practicing physician would see in a typical day. Given the large amount of time involved in these codes, the specialty society explained that two patients are typically seen by the physician per day for this service.

The RUC reviewed the robust survey data for 93654 and agreed that the survey 25th percentile of 20.00 work RVUs accurately accounts for the physician work involved in the service. To justify this value, the RUC compared the surveyed code to CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU= 20.00) and agreed that the two services should be valued the same given the similar physician work and total service times, 319 minutes and 323 minutes, respectively. In addition, the RUC compared 93654 to the base code 93653 and agreed that given the additional work involved in 93654, including the additional 3-D mapping and left ventricular pacing and recording, a work RVU of 20.00 appropriately ranks 93654 in relation to the base code. **The RUC recommends a work RVU of 20.00 for CPT code 93654.**

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93655 *Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia*

The RUC reviewed the survey results from 181 cardiologists who perform this service and recommend 90 minutes intra-service time for this add-on code. The RUC reviewed the robust survey data for 93655 and agreed that the survey 25th percentile of 9.00 work RVUs accurately accounts for the physician work involved in the service. The RUC compared the surveyed code to CPT code 35306 *Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery* (work RVU= 9.25) and agreed that with identical intra-service time of 90 minutes, the two codes should be valued similarly. Given this strong comparison and the strong data presented by the specialty society, the RUC agreed that a work RVU of 9.00 places 93655 in appropriate relativity in comparison to the family of services and across the RBRVS. **The RUC recommends a work RVU of 9.00 for CPT Code 93655.**

93656 *Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of atrial fibrillation by ablation by pulmonary vein isolation*

The RUC reviewed the survey results from 181 cardiologists who perform the service and recommend the following physician work time components: 39 minutes pre-service time, 240 minutes intra-service time and 40 minutes post-service time. The RUC discussed two issues related to the physician time for this service. First, the RUC discussed the time variation between the bundled 93656 code and the previously reported codes. It was noted that the current survey has almost 150 more survey respondents than the previous surveys. Thus, the RUC determined that these current survey data in both physician work and time are the best measure for the valuation of this service. Second, the RUC discussed the typical number of patients a practicing physician would see in a typical day. Given the large amount of time involved in these codes, the specialty society explained that two patients are typically seen by the physician per day for this service.

The RUC reviewed the robust survey data for 93656 and agreed that the survey 25th percentile of 20.02 work RVUs accurately accounts for the physician work involved in the service. To justify this value, the RUC compared the surveyed code to CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU= 20.00) and agreed that the two services should be valued the same given the similar physician work and total service times, 319 minutes and 323 minutes, respectively. Finally, the RUC compared 93656 to the family of services and agreed that this code should be valued almost identically to 93654 given the analogous physician time and work. **The RUC recommends a work RVU of 20.02 for CPT code 93656.**

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93657 *Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation*

The RUC reviewed the survey results from 181 cardiologists who perform this service and recommend 90 minutes intra-service time for this add-on code. The RUC reviewed the robust survey data for 93657 and agreed that the survey 25th percentile of 10.00 work RVUs accurately accounts for the physician work involved in the service. The RUC compared the surveyed code to CPT code 35306 *Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery* (work RVU= 9.25) and agreed that with identical intra-service time of 90 minutes, the two codes should be valued similarly. In addition, the RUC compared 93657 to the other add-on service in the family 93655 and noted that while the times are identical, 93657 is a more intense service. This increased intensity is validated through the survey results which show that 93657 was rated as a more intense service compared to 93655 in every intensity/complexity measure. **The RUC recommends a work RVU of 10.00 for CPT Code 93657.**

CPT Discussion:
During the deliberations, the RUC questioned whether the reprogramming of the implantable cardioverter-defibrillator was inherent in these services. The specialty societies indicated that should reprogramming be required at the time of the comprehensive electrophysiologic evaluation, that work would be considered inclusive of the service. Therefore, the CPT Editorial Panel at the February 2012 meeting, included in the parenthetical notes that CPT code 93642 is a code not to be reported in conjunction with 93653, 93654 and 93656.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense:
These services are primarily performed in the facility setting and no direct practice expense inputs are recommended.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Medicine, Cardiovascular** **Therapeutic Services and Procedures**				
⊙92960		Cardioversion, elective, electrical conversion of arrhythmia; external	000	2.25 (No Change)
⊙92961		internal (separate procedure) (Do not report 92961 in conjunction with 93282-93284, 93287, 93289, 93295, 93296, 93618-93624, 93631, 93640-93642, 93650~~-93654~~, 93653-93657~~93652~~, 93662)	000	4.59 (No Change)

Cardiac Catheterization

Right heart catheterization includes catheter placement in one or more right-sided cardiac chamber(s) or structures (ie, the right atrium, right ventricle, pulmonary artery, pulmonary wedge), obtaining blood samples for measurement of blood gases, and cardiac output measurements (Fick or other method), when performed. Left heart catheterization involves catheter placement in a left-sided (systemic) cardiac chamber(s) (left ventricle or left atrium) and includes left ventricular injection(s) when performed. Do not report ~~code~~ 93503 in conjunction with other diagnostic cardiac catheterization codes. When right heart catheterization is performed in conjunction with other cardiac catheterization services, report 93453, 93456, 93457, 93460, or 93461. For placement of a flow directed catheter (eg, Swan-Ganz) performed for hemodynamic monitoring purposes not in conjunction with other catheterization services, use 93503. Right heart catheterization does not include right ventricular or right atrial angiography (93566). When left heart catheterization is performed using either transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93452, 93453, 93458-93461, 9365~~93651~~93654~~,~~ ~~and~~ 9365~~393652~~. Catheter placement(s) in coronary artery(ies) involves selective engagement of the origins of the native coronary artery(ies) for the purpose of coronary angiography. Catheter placement(s) in bypass graft(s) (venous, internal mammary, free arterial graft[s]) involve selective engagement of the origins of the graft(s) for the purpose of bypass angiography. It is typically performed only in conjunction with coronary angiography of native vessels.

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⊙+93462		Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure) (Use 93462 in conjunction with 93452, 93453, 93458-93461, 93653, 9365493651, 93652) (Do not report 93462 in conjunction with 93656)	ZZZ	3.73 (No Change)

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Intracardiac Electrophysiological Procedures/Studies

Intracardiac electrophysiologic studies (EPS) are ~~an~~ invasive diagnostic medical procedures which include the insertion and repositioning of electrode catheters, recording of electrograms before and during pacing, ~~or~~ programmed stimulation of multiple locations in the heart, analysis of recorded information, and report of the procedure. ~~Electrophysiologic studies are most often performed with two or more electrode catheters.~~ In many circumstances, patients with arrhythmias are evaluated and treated at the same encounter. In this situation, a diagnostic *electrophysiologic study* is performed, induced tachycardia(s) are *mapped*, and on the basis of the diagnostic and mapping information, the tissue is *ablated*. ~~Electrophysiologic study(ies), mapping, and ablation represent distinctly different procedures, requiring individual reporting whether performed on the same or subsequent dates.~~

Definitions

Arrhythmia Induction: In most electrophysiologic studies, an attempt is made to induce arrhythmia(s) from single or multiple sites within the heart. Arrhythmia induction may be ~~is~~ achieved by multiple techniques, eg, by performing pacing at different rate~~s~~ or programmed stimulation (introduction of critically timed electrical impulses)~~, and other techniques~~. Because arrhythmia induction occurs via the same catheter(s) inserted for the electrophysiologic study(ies), catheter insertion and temporary pacemaker codes are not additionally reported. Codes 93600-93603, 93610~~-~~, 93612 and 93618 are used to describe unusual situations where there may be recording, pacing or an attempt at arrhythmia induction from only one site in the heart. Code 93619 describes only evaluation of the sinus node, atrioventricular node and His-Purkinje conduction system, without arrhythmia induction. Codes 93620-93624, ~~and~~ 93640-93642, 93653, 93654, and 93656 all include recording, pacing and attempted arrhythmia induction from one or more site(s) in the heart.

Mapping: ~~Mapping is a distinct procedure performed in addition to a diagnostic electrophysiologic procedure and should be separately reported using 93609 or 93613. Do not report standard mapping (93609) in addition to 3D mapping (93613).~~ When a tachycardia is induced, the site of tachycardia origination or its electrical path through the heart is often defined by mapping. Mapping creates a multidimensional depiction of a tachycardia by recording multiple electrograms obtained sequentially or simultaneously from multiple catheter sites in the heart. Depending upon the technique, certain types of mapping catheters may be repositioned from point-to-point within the heart, allowing sequential recording from the various sites to construct maps. Other types of mapping catheters allow mapping without a point-to-point technique by allowing simultaneous recording from many electrodes on the same catheter and computer-assisted three dimensional reconstruction of the tachycardia activation sequence.

Mapping is a distinct procedure performed in addition to a diagnostic electrophysiologic study or ablation procedure and may be separately reported using 93609 or 93613. Do not report standard mapping (93609) in addition to 3D mapping (93613).

Ablation: Once the part of the heart involved in the tachycardia is localized, the tachycardia may be treated by ablation (the delivery of a radiofrequency or cryo-energy to the area to selectively destroy cardiac tissue). Ablation procedures (~~93651-93652~~ 93653-9365~~7~~6)

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~~may be performed: independently on a date subsequent to a diagnostic electrophysiologic study and mapping; or, at the time a diagnostic electrophysiologic study, tachycardia(s) induction and mapping is performed. When an electrophysiologic study, mapping, and ablation are performed on the same date, each procedure should be separately reported. In reporting catheter ablation, 93651 and/or 93652 should be reported once to describe ablation of cardiac arrhythmias, regardless of the number of arrhythmias ablated~~ are ~~commonly~~ performed at the same session as electrophysiology studies and therefore represent a combined code description. When reporting ablation therapy codes (93653-9365~~6~~7), the single site electrophysiology studies (93600-93603, 93610, 93612, 93618) and the comprehensive electrophysiology studies (93619, 93620) may not be reported separately. Codes 93622 and 93623 may be reported separately with 93656 for treatment of atrial fibrillation. However, 93621 for left atrial pacing and recording from coronary sinus or left atrium should not be reported in conjunction with 93656 as this is a ~~standard~~ component of 93656~~ the procedure~~.

The differences in the techniques involved for ablation of supraventricular arrhythmias, ventricular arrhythmias, and atrial fibrillation are reflected within the descriptions for 93653-9365~~6~~7. Code 93653 is a primary code for catheter ablation for treatment of supraventricular tachycardia caused by dual atrioventricular nodal pathways, accessory atrioventricular connections, or other atrial foci. Code 93654 describes catheter ablation for treatment of ventricular tachycardia or focus of ventricular ectopy. Code 93656 is a primary code for reporting treatment of atrial fibrillation by ablation to achieve complete pulmonary vein electrical isolation. Codes 93653, 93654, and 93656 are distinct primary procedure codes and may not be reported together.

Codes 93655 and 93657 are add-on codes listed in addition to the primary ablation code to report ablation of sites distinct from the primary ablation site. After ablation of the primary target site, post-ablation electrophysiologic evaluation is performed as part of those ablation services (93653, 93654, 93656) and additional mechanisms of tachycardia may be identified. For example, if the primary tachycardia ablated was atrioventricular nodal reentrant tachycardia and during post-ablation testing an atrial tachycardia, atrial flutter or accessory pathway with orthodromic reentry tachycardia was identified, this would be considered a separate mechanism of tachycardia. Pacing maneuvers are performed to define the mechanism(s) of the new tachycardia(s). Catheter ablation of this distinct mechanism of tachycardia is then performed at the newly discovered atrial or ventricular origin. Appropriate post-ablation attempts at re-induction and observation are again performed. Code 93655 is listed in conjunction with 93653 when repeat ablation is for treatment of an additional supraventricular tachycardia mechanism and with 93654 when the repeat ablation is for treatment of an additional ventricular tachycardia mechanism. Code 93655 may be reported with 93656 when an additional non-atrial fibrillation tachycardia is separately diagnosed after pulmonary vein isolation. Code 93657 is reported in conjunction with 93656 when successful pulmonary vein isolation is achieved, attempts at re-induction of atrial fibrillation identify an additional left or right atrial focus for atrial fibrillation, and further ablation of this new focus is performed.

In certain circumstances, depending on the chamber of origin, a catheter or catheters may be maneuvered into the left ventricle to facilitate arrhythmia diagnosis. This may be accomplished via a retrograde aortic approach by means of the arterial access or through a transseptal puncture. For ablation treatment of supraventricular tachycardia (93653) and ventricular tachycardia (93654), the left heart catheterization by transseptal puncture through intact septum (93462) may be reported separately as an add-on code. However, for ablation treatment of atrial

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fibrillation (93656), the transseptal puncture (93462) is a standard component of the procedure and may not be reported separately. Do not report 93462 in conjunction with 93656. ~~In certain circumstances, percutaneous catheter access is required in the pericardial space to facilitate mapping and ablation as well as pacing maneuvers along the epicardial surface of the heart to facilitate eradication of ventricular tachycardia. Once the tachycardia circuit or focus is localized a catheter is moved via venous, arterial or percutaneous epicardial access to the appropriate location to deliver ablative energy.~~ *Modifier 51 should not be appended to 93600-93603, 93610, 93612, 93615-93618, 93631.*				
⊙+93609		Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure) (Use 93609 in conjunction with 93620, 93653~~, 9365493651, 93652~~) (Do not report 93609 in addition to 93613)	ZZZ	0.00 (No Change)
⊙+93613		Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) (Use 93613 in conjunction with 93620, 93653, ~~9365493651, 93652~~) (Do not report 93613 in addition to 93609	ZZZ	6.99 (No Change)
⊙+93621		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure) (Use 93621 in conjunction with 93620) (Do not report 93621 in conjunction with 93656)	ZZZ	2.10 (No Change)

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D ⊙93651		~~Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination~~	000	N/A
D ⊙93652		~~for treatment of ventricular tachycardia~~ (93651, 93652 have been deleted. To report, see 93653-93657)	000	N/A
⊙●93653	Q1	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry (Do not report 93653 in conjunction with 93600-93603, 93610, 93612, 93618-93620, 93654)	000	15.00
⊙●93654	Q2	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed (Do not report 93654 in conjunction with 93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, 93642, 93653)	000	23.40

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⊙+●93655	Q3	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure) (Use 93655 in conjunction with 93653 or 93654 or 93656	ZZZ	9.00
⊙●93656	Q4	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation (Do not report 93656 in conjunction with 93462, 93600, 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93621, 93462, 93653, 93654)	000	23.40
⊙+●93657	Q5	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure) (Use 93657 in conjunction with 93656)	ZZZ	10.00
+93662		Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) (Use 93662 in conjunction with 92987, 93453, 93460-93462, 93532, 93580, 93581, 93621, 93622, 93653, 93654, 9365693651, or 93652 as appropriate) (Do not report 92961 in addition to 93662)	ZZZ	2.80 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93653 Tracking Number O1 Original Specialty Recommended RVU: **18.00**
Presented Recommended RVU: **18.00**
Global Period: 000 RUC Recommended RVU: **15.00**

CPT Descriptor: Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
(Do not report 93653 in conjunction with 93600-93603, 93610, 93612, 93618-93620, 93654)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old woman has recurrent palpitations. An event monitor has documented supraventricular tachycardia.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 76%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The procedure and the risks, benefits and alternatives associated with electrophysiology testing and supraventricular tachycardia ablation are explained to the patient and patient's family. Arrangements are made for the x-ray technician, electrophysiology laboratory technician and nurse. Informed consent is obtained. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory testing is reviewed as well as current medications and changes in health status. Informed consent is obtained.

Description of Intra-Service Work: The patient is brought to the electrophysiology lab. Direct-current cardioversion/defibrillation and EP testing/ablation equipment is confirmed present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Local analgesia is administered along with anesthesia appropriate to the patient including moderate sedation. Venous access is obtained. In addition, arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle is obtained. Multi-electrode catheters are advanced from the access sheaths and into the respective cardiac chambers where they will be used to pace and record. Pacing and sensing is performed in the right atrium and right ventricle. His bundle recording is obtained. Refractory periods are measured. Attempts at arrhythmia induction are performed. via maneuvers that include burst pacing and premature pacing using programmed electrical stimulation at multiple drive cycle lengths from multiple atrial and ventricular sites. Once the SVT is induced, pacing maneuvers are performed to elucidate the mechanism of the tachycardia. Once the combination of both diagnostic maneuvers and mapping is complete, catheter ablation may be performed. An ablation catheter is maneuvered from the sites of vascular access to the appropriate cardiac location to

facilitate delivery of ablative energy. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue. Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, brady- or tachyarrhythmias, embolic phenomena or damage to cardiac or vascular structures. Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst and premature pacing maneuvers. These are repeated following a 30-minute period following the conclusion of the final ablation lesion. Sheaths are removed, appropriate hemostasis is achieved and follow-up assessment of the patient for any complications is performed.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family and post-procedure assessments are performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Mark Schoenfeld, MD, FHRS; Richard Wright, MD, FACC				
Specialty(s):	Heart Rhythm Society, American College of Cardiology				
CPT Code:	93653				
Sample Size:	626	**Resp N:**	182	**Response:** 29.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	46.00	**60.00**	90.00	250.00
Survey RVW:	5.30	15.00	**18.00**	25.00	55.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	120.00	**180.00**	180.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	93653	**Recommended Physician Work RVU: 15.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 44 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 93653**	**Key Reference CPT Code:** 93580	**Source of Time RUC Time**
Median Pre-Service Time	39.00	30.00	
Median Intra-Service Time	180.00	120.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**249.00**	**210.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.39	3.49
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.37	3.97
Urgency of medical decision making	3.98	3.79
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.73	4.59
Physical effort required	4.15	3.92
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.43	4.33
Outcome depends on the skill and judgment of physician	4.80	4.54
Estimated risk of malpractice suit with poor outcome	4.70	4.49

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.15	3.28
Intra-Service intensity/complexity	4.49	4.28
Post-Service intensity/complexity	2.88	2.85

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was created after electrophysiology studies (93620) and ablation procedures (93651 and 93652) were identified in the RAW's screen for services that are reported together 75% of the time. Specifically, the screen found

that 93620 and 93651 were reported together 83% of the time, and that 93620 and 93652 were reported together 89% of the time.

Identifying comparison codes on the MPC list was extremely difficult due to: the high number of work values for the procedure; that many codes on the MPC list with similar times and/or values had 90-day global periods; and that similar codes such as percutaneous cardiac interventions (stents), are also being reviewed for this RUC meeting.

Prior to conducting the survey, we convened a conference call with the Research Subcommittee to review our reference service list since the majority of electrophysiology services were included in the new code descriptors, plus many other cardiac services were also being surveyed for this RUC meeting. That left surveyees with limited choices of services that they perform while still affording a list of services encompassing a broad spectrum of work values. The Subcommittee recommended minor changes and we incorporated all of them.

Our survey returned nearly a 30% response rate with over 179 completed surveys for each code. Given the limits in finding comparison codes due to the high number of work relative values per new code we compared the survey's median and 25th percentile of times and values to the existing codes in order to validate our work value recommendation.

To compare the existing and new codes we applied the multiple payment procedure reduction (MPPR) to the times and values. We also computed the IWPUT for the existing and new codes as an additional point of comparison in an effort to identify any anomalies that our survey responses could have created. Both sources of comparison indicate that our survey data is valid.

We considered the decrease in time between the existing and new, bundled code(s) and found that some of the former inputs used to value the electrophysiology study and ablation services we're based on technologies that are not typically used anymore, and that the patients eligible to receive these services have changed. For example, while technology is more advanced, the knowledge and accuracy required to perform the procedures has increased. In addition, ablation services used to be available primarily for patients who had no other co-morbidities and who were younger. Within the past two-to-five years, Medicare-age patients have become more likely to be eligible to undergo ablations for atrial fibrillation and tachycardial disorders because of technological advances. Plus, due to their advanced age, it is more likely that they will have an intracardiac defibrillator in place and that the patient will have received multiple shocks before being ablated. Medicare-eligible patients are becoming a much larger percentage of the population receiving this care.

For 93653, we recommend a work value of 18.00, which is equal to the survey median. While the RVW is less than the existing work value for the unbundled services, our survey data could not justify maintaining the current work values. In comparing the code with key reference service, 93580 (repair of atrial septal defect) we noted longer reported intra-service times for 93653 and slightly higher intra-service intensity, technical skill, and mental effort ratings justifying the median value of 18.00. As an additional point of comparison, we calculated that the IWPUT for the newly bundled codes, using the 18.00 RVWs, and found that it falls nearly equal to the intensity to the other two similar codes that we surveyed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was previously reported using 93620 (electrophysiology study) and 93651 (intracardiac catheter ablation).

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The majority of these services will be provided by electrophysiologists. Access to electrophysiology services would be the most typical reason for the procedure to be conducted by cardiologists. Information to this effect will become more evident once CMS has collected utilization data incorporating the new specialty designation (effective 7/1/2011) for electrophysiology.

Specialty Electrophysiology Frequency 21420 Percentage 70.00 %

Specialty Cardiology Frequency 9180 Percentage 30.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,598 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 42% of 93651 will be reported in this code

Specialty Electrophysiology Frequency 12000 Percentage 76.93 %

Specialty Cardiology Frequency 5000 Percentage 32.05 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93620

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93654 Tracking Number O2 Original Specialty Recommended RVU: **23.40**
Presented Recommended RVU: **25.00**
Global Period: 000 RUC Recommended RVU: **20.00**

CPT Descriptor: Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3-dimensional mapping, when performed and left ventricular pacing and recording, when performed
(Do not report 93654 in conjunction with 93600-93603, 93610, 93612, 93613, 93618-93620, 93622, 93653)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old man with a history of New York Heart Association Class III heart failure due to ischemic dilated cardiomyopathy (EF 25%) and prior myocardial infarction presents with recurrent ICD therapies for drug-refractory ventricular tachycardia.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 77%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting?

Description of Pre-Service Work: Transthoracic echocardiography and, if necessary, transesophageal echocardiography are obtained prior to the procedure to rule-out left ventricular thrombus and to assess the aortic arch for presence of atherometous plaques. The procedure and the risks, benefits and alternatives associated with electrophysiology testing and ventricular tachycardia ablation are explained to the patient and patient's family. Arrangements are made for the x-ray technician, electrophysiology laboratory technician and nurse. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory testing, medications and changes in heath are reviewed. Informed consent is obtained.

Description of Intra-Service Work: The patient is brought to the electrophysiology laboratory. Direct-current cardioversion/defibrillation, EP and ablation equipment is confirmed present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Three-dimensional mapping equipment is tested and confirmed to be functioning normallyLocal analgesia is administered. Patients with implantable cardioverter-defibrillators will have their devices reprogrammed and/or transiently deactivated at the start of the case so as to minimize adverse consequences resulting from electromagnetic interference from radiofrequency current application.
Venous access is obtained In addition, arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle is obtained. Multi-electrode catheters are advanced from the access sheaths and into the respective cardiac chambers where they will be used to pace and record. An intracardiac echo probe is placed via a femoral venous access

approach. The intracardiac echo is used in conjunction with the 3-D mapping system to create a 3-dimensional shell of the right or left ventricle, including the aortic root, aortic valve leaflets, coronary ostia and mitral valve annulus. Papillary muscles are also recorded in the 3-dimensional anatomical ultrasound map. Pacing and sensing is performed in the right atrium and right ventricle. His bundle recording is obtained. Refractory periods are measured. Attempts at ventricular tachycardia induction are performed via burst pacing, decremental pacing and premature pacing using programmed electrical stimulation at multiple drive cycle lengths from multiple ventricular sites.

Once an arrhythmia is induced, pacing maneuvers are performed to elucidate the mechanism of the ventricular tachycardia. The electrical activation sequence is mapped with the 3-dimensional electroanatomical mapping system and activation timing is superimposed upon the 3-dimensional echo image previously obtained. Anticoagulation is administered once catheters have been placed on the left side of the heart. Once the ventricular tachycardia circuit is localized, a catheter is moved to the appropriate location or region of abnormal myocardium to deliver ablative energy. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue. Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, brady- or tachyarrhythmias, embolic phenomena or damage to cardiac or vascular structures.

Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst and premature pacing maneuvers. These are repeated following a 30-minute period following the conclusion of the final ablation lesion. Anticoagulation is reversed. Sheaths are removed, appropriate hemostasis is achieved and follow-up assessment of the patient for any complications is performed. Patients with implantable cardioverter-defibrillators will have their devices reprogrammed to an active configuration with rates reprogrammed as necessary to treat any remaining arrhythmias.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient’s family and post-procedure assessments are performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Mark Schoenfeld, MD, FHRS; Richard Wright, MD, FACC		
Specialty(s):	Heart Rhythm Society, American College of Cardiology		
CPT Code:	93654		
Sample Size:	626	**Resp N:** 179	**Response:** 28.5 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	30.00	150.00
Survey RVW:	5.00	20.00	**25.00**	31.37	90.40
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	180.00	**240.00**	300.00	540.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	93654	**Recommended Physician Work RVU: 20.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 50 **% of respondents:** 27.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 93654**	**Key Reference CPT Code:** 93581	**Source of Time** RUC Time
Median Pre-Service Time	39.00	30.00	
Median Intra-Service Time	240.00	180.00	
Median Immediate Post-service Time	40.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**319.00**	**270.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.80	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.82	4.42
Urgency of medical decision making	4.76	4.02
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.94	4.60
Physical effort required	4.71	4.24
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.90	4.53
Outcome depends on the skill and judgment of physician	4.96	4.62
Estimated risk of malpractice suit with poor outcome	4.52	4.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.24	3.82
Intra-Service intensity/complexity	4.98	4.64
Post-Service intensity/complexity	4.10	3.87

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was created after electrophysiology studies and ablation procedures were identified in the RAW's screen for services that are reported together 75% of the time. Specifically, the screen found that 93620 and 93651 were reported together 83% of the time, and that 93620 and 93652 were reported together 89% of the time.

Identifying comparison codes on the MPC list was extremely difficult due to the high number of work values for the procedure, that many codes on the MPC list with similar values had 90-day global periods, and that codes with equal global periods, such as per cutaneous cardiac interventions (PCI) stents were also being reviewed for this RUC meeting.

Prior to conducting the survey, we convened a conference call with the Research Subcommittee to review our reference service list since the majority of electrophysiology services were included in the new code descriptors, plus many other cardiac services were also being surveyed for this RUC meeting. That left surveyees with limited choices of services that they perform while still affording a list of services encompassing a broad spectrum of work values. The Subcommittee recommended minor changes and we incorporated all of them.

Our surveys returned nearly a 30% response rate with over 179 completed surveys for each code. Given the limits in finding comparison codes due to the high number of work relative values per new code we compared the surveys' median and 25th percentile of times and values to the existing codes in order to validate our work value recommendations.

To compare the existing and new codes we applied the multiple payment procedure reduction (MPPR) to the times and values. We also computed the IWPUT for the existing and new codes as an additional point of comparison in an effort to identify any anomalies that our survey responses could have created.

Both sources of comparison indicate that our survey data is valid.

The intra-service time is slightly less than what is captured under the MPPR calculations. In reviewing the changes in times, we found that some of the former inputs used to value the electrophysiology study and ablation services we're based on technologies that are not typically used anymore, and that the patients eligible to receive these services have changed. For example, while technology is more advanced, the knowledge and accuracy required to perform the procedures has increased. In addition, ablation services used to be available primarily for patients who had no other co-morbidities and who were younger. Today, Medicare-age patients are more likely to be eligible to undergo ablations for atrial fibrillation and tachycardial disorders because of technological advances.

For 93654, we recommend the 23.40 work units. This value is between the 25th and 50th percentiles of the survey data and matches the existing work value for the unbundled services (93652 and 93620). In comparing the new code with key reference service 93581 (Percutaneous transcatheter closure of a congenital ventricular septal defect with implant) we determined that even though the intra-service time to perform the surveyed code is longer, the intensity of the reference service is greater. Patients undergoing the surveyed code and the reference service are fragile, either due to age (infants or the elderly) or co-morbidities. We found the work similar yet not close to enough for the new code to warrant a value greater than the currently existing one for the unbundled services (CPT 93652 and 93620). The recommended value recognizes the added complexity of the patient's status, physician's work and the IWPUT reference point is nearly equal to that of the existing one for the combined unbundled codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93652 in addition to 93620

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Electrophysiology How often? Sometimes

Specialty Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. With Medicare patients equaling half of the patient population receiving this service, we doubled the annual Medicare utilization of 2,961 and added roughly 500 aptients to account for increasing numbers of patients eligible to undergo the procedure.

Specialty Electrophysiology Frequency 4250 Percentage 70.83 %

Specialty Cardiology Frequency 1750 Percentage 29.16 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,012
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. With patients becoming increasingly more eligible to receive these services, we anticipate a slight increase in the currently reported utilization rate of 2961

Specialty Electrophysiology Frequency 2500 Percentage 83.00 %

Specialty Cardiology Frequency 800 Percentage 26.56 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93620

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

59 New Molecular Pathology Services

Global Period:_XXX Meeting Date: _September 2011

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

TAB 5 – All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011), except for the HLA code set where CAP surveyed several large and small labs throughout the United States. Survey responses were compiled; questions and clarifications were followed up with lab managers and directors. CAP's expert panel reviewed compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment for all codes.

TAB 9 – All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011).

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Molecular DNA analyses based on specific code.

Intra-Service Clinical Labor Activities:

NONE

Post-Service Clinical Labor Activities:
Clean up, document filing, and other activities, see spreadsheet

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93656 Tracking Number O4 Original Specialty Recommended RVU: **23.40**
Presented Recommended RVU: **23.40**
Global Period: 000 RUC Recommended RVU: **20.02**

CPT Descriptor: Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of atrial fibrillation by ablation by pulmonary vein isolation
(Do not report 93656 in conjunction with 93600, 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93621, 93462, 93653, 93654)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old man with a history of hypertension has recurrent atrial fibrillation. Despite rate or rhythm control with antiarrhythmic drugs, he remains symptomatic.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 81%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting?

Description of Pre-Service Work: A 3-D imaging study such as cardiac MRI, or CT scanning is be obtained prior to the procedure to assess atrial size and for pulmonary vein anatomic variants. The procedure and the risks, benefits and alternatives associated with electrophysiology testing and ventricular tachycardia ablation are explained to the patient and patient's family. Arrangements are made for the x-ray technician, electrophysiology laboratory technician and nurse. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory, medications and change in health status are reviewed with careful attention to the degree of anticoagulation. Informed consent is obtained.

Description of Intra-Service Work: The patient is brought to the electrophysiology laboratory. Direct-current cardioversion/defibrillation, EP and ablative equipment is confirmed present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Local analgesia is administered. Venous access is obtained. In addition, arterial access to monitor blood pressure and to retrograde aortic access to the left ventricle is be obtained. By means of the venous access sites, multi-electrode catheters are positioned in specific cardiac chambers. Two transseptal catheterizations are performed to achieve access and facilitate placement of both a circular mapping catheter and an ablation catheter in the left atrium. Additional anticoagulation is administered. Conduction intervals and refractory periods are measured and arrhythmia induction attempted. His bundle recording and ventricular pacing and sensing are performed. A circular mapping catheter is passed into the left atrium and pulmonary vein conduction is assessed and recorded. Selective venography of the pulmonary veins is performed to define anatomy.

Catheter ablation is then performed to achieve pulmonary vein isolation. Point lesions encircling the pulmonary vein region are created that guided by anatomical mapping and electrical signals provided by a circular mapping catheter. Pulmonary vein isolation, as measured by the circular mapping catheter as well as loss of tissue voltage and tissue pacing capture are the measured endpoints. Throughout the ablation the patient is monitored hemodynamic compromise due to cardiac perforation, brady- or tachyarrhythmias, embolic phenomena, thrombus formation or damage to cardiac or vascular structures, including meticulous monitoring for lesion delivery within the pulmonary vein or close to the esophagus. Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation over a 30-minute period following the last ablation lesion. Once electrophysiology testing and ablation are completed, anticoagulation is reversed. Post procedure, sheaths are removed, appropriate hemostasis is achieved and follow-up assessment of the patient for any complications is performed.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family and a post-procedure assessment is performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	Mark Schoenfeld, MD, FHRS; Richard Wright, MD, FACC					
Specialty(s):	Heart Rhythm Society, American College of Cardiology					
CPT Code:	93656					
Sample Size:	626	**Resp N:**	181	**Response:** 28.9 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**40.00**	75.00	200.00
Survey RVW:	7.00	20.02	**25.00**	35.00	81.36
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	75.00	210.00	**240.00**	300.00	640.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	93656	**Recommended Physician Work RVU: 20.02**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11004	000	10.80	**RUC Time**	2,682

CPT Descriptor 1 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 47 **% of respondents:** 25.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 93656**	**Key Reference CPT Code:** 93581	**Source of Time** RUC Time
Median Pre-Service Time	39.00	30.00	
Median Intra-Service Time	240.00	180.00	
Median Immediate Post-service Time	40.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**319.00**	**270.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.40	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.73	4.25
Urgency of medical decision making	4.38	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.98	4.61
Physical effort required	4.86	4.39
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.91	4.64
Outcome depends on the skill and judgment of physician	4.98	4.77
Estimated risk of malpractice suit with poor outcome	4.73	4.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.29	4.00
Intra-Service intensity/complexity	4.98	4.61
Post-Service intensity/complexity	4.24	3.98

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was created after electrophysiology studies and ablation procedures were identified in the RAW's screen for services that are reported together 75% of the time. Due to the increasing number of patients undergoing ablations for atrial fibrillation, this code's development was warranted.

Identifying comparison codes on the MPC list was extremely difficult due to the number of work values for the procedure, that many codes on the MPC list with similar values had 90-day global periods, and that codes with equal global periods, such as per cutaneous cardiac interventions (PCI) stents were also being reviewed for this RUC meeting.

To compare the existing and new codes we applied the multiple payment procedure reduction (MPPR) to the times and values. We also computed the IWPUT for the existing and new codes as an additional point of comparison in an effort to identify any anomalies that our survey responses could have created.

Both sources of comparison indicate that our survey data is valid.

In reviewing the changes in times compared to the existing, unbundled services, we found that some of the former inputs used to value the electrophysiology study and ablation services were based on technologies that are not typically used anymore, and that the patients eligible to receive these services have changed. For example, while technology is more advanced, the knowledge and accuracy required to perform the procedures has increased. In addition, ablation services used to be available primarily for patients who had no other co-morbidities and who were below Medicare-age. Today, Medicare-age patients are more likely to be eligible to undergo ablations for atrial fibrillation and tachycardial disorders because of technological advances.

For 93656, we recommend the 23.40 work units. This value is between the 25th percentile and the median of the survey data and matches the existing work value for the unbundled services (93652 and 93620). We are applying the same rationale that we utilized for 93654 since the time, intensity and complexity of the work are identical. In comparing the new code with key reference service 93581 (Percutaneous transcatheter closure of a congenital ventricular septal defect with implant) we determined that even though the intra-service time to perform the surveyed code is longer, the intensity of the reference service is greater. Patients undergoing the surveyed code and the reference service are fragile, either due to age (infants or the elderly) or co-morbidities. We found the work similar yet not close to enough for the new code to warrant a value greater than the currently existing one for the unbundled services (CPT 93652 and 93620). The recommended value recognizes the added complexity of the patient's status, physician's work and the IWPUT reference point is nearly equal to that of the existing one for the combined unbundled codes.

The recommended value recognizes the added complexity of the patient's status, physician's work and the IWPUT reference point as being nearly equal to that of the existing value for the combined unbundled codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93651 in addition to 93620

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The majority of these services will be provided by electrophysiologists. Access to electrophysiology services would be the most typical reason for the procedure to be conducted by cardiologists. Information to this effect will become more evident once CMS has collected utilization data incorporating the new specialty designation (effective 7/1/2011) for electrophysiology.

Specialty Electrophysiology Frequency 21420 Percentage 70.00 %

Specialty Cardiology Frequency 9180 Percentage 30.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,145 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 42% of 93651 and 90% of 93462 will reported in this code.

Specialty Electrophysiology Frequency 14102 Percentage 70.00 %

Specialty Cardiology Frequency 6045 Percentage 30.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93620

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93657 Tracking Number O5 Original Specialty Recommended RVU: **10.00**
Presented Recommended RVU: **10.00**
Global Period: ZZZ RUC Recommended RVU: **10.00**

CPT Descriptor: Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)
(Use 93657 in conjunction with 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man has symptomatic atrial fibrillation refractory to medical therapy. EP study and ablation are performed to achieve pulmonary vein isolation. (Reported separately). Despite demonstration of electrical isolation of the pulmonary veins, atrial fibrillation continues.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 8% , In the ASC 83%, In the office 41%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 83%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: A full electrophysiologic study and ablation procedure has been performed for atrial fibrillation. Diagnostic and ablation catheters are present in cardiac chambers. Pulmonary vein isolation has been accomplished. Due to the presence of non-pulmonary vein sources of atrial fibrillation, additional non-pulmonary vein ablation lesions are created. Regions of fractionated potentials are mapped and ablated outside the pulmonary vein area. In addition, linear lesions are attempted along the roof, mitral isthmus or septal aspect of the left atrium. Non-pulmonary vein focal sources of atrial fibrillation induction are induced, localized and ablated. These lesion locations are distinct from the pulmonary vein lesions performed in the main EP study/atrial fibrillation ablation procedure. During the delivery of ablation energy, continuous monitoring for hemodynamic instability, arrhythmias, embolic events and injury to the esophagus is performed. Following restoration of sinus rhythm, conduction intervals are measured and arrhythmia induction is re-attempted over a 30-minute period following the last ablation lesion.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Mark Schoenfeld, MD, FHRS; Richard Wright, MD, FACC		
Specialty(s):	Heart Rhythm Society, Amercian College of Cardiology		
CPT Code:	93657		
Sample Size: 626	**Resp N:** 181	**Response:** 28.9 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	35.00	150.00
Survey RVW:	5.00	10.00	**15.00**	20.00	54.24
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	60.00	**90.00**	120.00	360.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code: 93657	**Recommended Physician Work RVU: 10.00**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**90.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33259	ZZZ	14.14	**RUC Time**

CPT Descriptor Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 19.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 93657**	**Key Reference CPT Code:** 33259	**Source of Time RUC Time**
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	90.00	48.00	
Median Immediate Post-service Time	0.00	15.00	
Median Critical Care Time	0.0	35.00	
Median Other Hospital Visit Time	0.0	45.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	0.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**90.00**	**223.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.66	3.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.78	4.17
Urgency of medical decision making	4.41	4.10
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.97	4.70
Physical effort required	4.69	4.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.88	4.60
Outcome depends on the skill and judgment of physician	4.94	4.73
Estimated risk of malpractice suit with poor outcome	4.63	4.37

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.88	4.66
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was created after electrophysiology studies and ablation procedures were identified in the RAW's screen for services that are reported together 75% of the time. In addition to developing codes that bundle the primary services, this code is an add-on procedure for those cases when additional spontaneous or induced arrhythmias require further ablation.

For 93657, we chose the survey's 25th percentile of 10.00 WRVUs. The intra-service time and the 25th percentile WRVU coincide with the complexity of the additional work that is required. Using magnitude estimation we compared the intra-service work and patient complexity of this code and our key reference service 33259 (Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure). That code has 14.14 RVUs with 239 total minutes, including pre and post-service work. Despite having a ZZZ global period, the unique nature of the service and the patient complexity warranted including pre and post-service times in the RVW. We also compared it to 22534 (Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure) which is on the MPC list. Valued at 5.99 RVWs with a total intra-service time of 60 minutes, we agreed that the patient complexity was closer to the surveyed code's typical patient. In addition, using IWPUT as a secondary comparator, the IWPUT for 22534 is .09998 compared to the 25th percentile's IWPUT of .1111.
We also compared the 93657 to our other surveyed code 9365X3 (Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia) for which we recommended 9.00 RVWs. We determined that while the patients receiving each service were similar, the intensity of the work for each service warranted the slight increase RVWs between the two codes.

Based on: Similarities in complexity between 93657 and 22534; the additional time and effort required to perform the code being surveyed compared to 22534; and, the increased work and complexity required of 33259 compared to the surveyed code, we are recommending the 25th percentile RVW of 10.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93651 and 93652

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Electrophysiology How often? Sometimes

Specialty Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticiapte this service being provided 5-10% of the time that the primary procedure is conducted.

Specialty Electrophysiology Frequency 2500 Percentage 71.42 %

Specialty Cardiology Frequency 1000 Percentage 28.57 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,381
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 8.5% of 93651 and 5.5% of 93652 will be reported in this code.

Specialty Electrophysiology Frequency 1600 Percentage 71.11 %

Specialty Cardiology Frequency 650 Percentage 27.77 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93620

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AF	AG	AH	AI	AJ
12	**ISSUE:**	**Bundling EPS-Transcatheter ablation**																														
13	**TAB:**	**11**																														
14								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**Office**				
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
16	**REF**	**93580**	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	**44**	**0.133**			**17.97**			**210**	**30**					**120**			**60**												
17	**CURRENT**	**93651+93620**	Comprehnsive electrophysiology study (93620), and Intracardiac catheter ablation of arrhythmogenic focus (93651) with multpile-procedure payment reduction		**-0.01**			**21.99**			**525**	**120**					**345**			**60**												
18	**SVY**	**93653**	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	**182**	**0.091**	**5.30**	**15.00**	**18.00**	**25.00**	**55.00**	**265**	**20**	**15**	**20**	**60**	**120**	**180**	**180**	**360**	**30**												
19	**REC**	**93653**			**0.077**			**15.00**			**236**	**20**	**1**	**5**			**180**			**30**												
20																																
21								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**Office**				
22	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
23	**REF**	**93581**	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	**50**	**0.124**			**24.39**			**270**	**30**					**180**			**60**												
24	**CURRENT**	**93652+93620+93613**	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia (93652), and comprehensive electrophsyiology study (93620) with mutiple procedure reduction, and 3D mapping (93613)		**-0.01**			**30.40**			**603**	**40**	**3**	**20**			**480**			**60**												
25	**SVY**	**93654**	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3-dimensional mapping, when performed and left ventricular pacing and recording, when performed	**179**	**0.095**	**5.00**	**20.00**	**25.00**	**31.37**	**90.40**	**350**	**30**	**20**	**20**	**60**	**180**	**240**	**300**	**540**	**40**												
26	**REC**	**93654**			**0.077**			**20.00**			**316**	**30**	**1**	**5**			**240**			**40**												
27																																
28								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**Office**				
29	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
30	**REF**	**33259**	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of generator)	**38**	**0.140**			**14.14**			**222.75**	**15**					**48**			**15**	**0.7**		**0.6**			**0.5**		**2**				
31	**CURRENT**		New Code		**#DIV/0!**																											
32	**SVY**	**93655**	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	**181**	**0.133**	**4.00**	**9.00**	**12.00**	**16.00**	**54.20**	**90**				**20**	**60**	**90**	**120**	**640**													
33	**REC**	**93655**			**0.100**			**9.00**			**90**						**90**															
34																																
35								**RVW**			**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**Office**				
36	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
37	**REF**	**93581**	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	**47**	**0.124**			**24.39**			**270**	**30**					**180**			**60**												
38	**CURRENT**	**93651+93620+93621+ 93462**	Intracardiac catheter ablation of arrhythmogenic focus (93651), comprehnsive electrophysiology study (93620) with multpile-procedure payment reduction, pacing and recording (93621), and transseptal puncture (93462)		**-0.01**			**27.82**			**595**	**120**					**415**			**60**												

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AF	AG	AH	AI	AJ
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office				
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11
39	SVY	93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of atrial fibrillation by ablation by pulmonary vein isolation (Do not report 9365X4 in conjunction with 93600, 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93621, 93462, 9365X1, 9365X2)	181	0.095	7.00	20.02	25.00	35.00	81.36	350	30	20	20	75	210	240	300	640	40										
40	REC	93656			0.077			20.02			316	30	1	5			240			40	0	0	0	0	0	0.0	0	0	0	0	0	0
41																																
42						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office				
43	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11
44	REF	33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	35	0.140			14.14			222.75	15					48			15	0.7		0.6			0.5				2			
45	CURRENT		New Code		#DIV/0!						0																					
46	SVY	93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	181	0.167	5.00	10.00	15.00	20.00	54.24	90				20	60	90	120	360														
47	REC	93657			0.111			10.00			90						90															
48																																

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Low Value-Billed in Multiple Units screen

April 2012

Percutaneous Allergy Testing

In 2011, CPT code 95010 *Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests* and 95015 *Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests* were identified as part of the Low Value-Billed in Multiple Units screen. In April 2011, the RUC reviewed survey data for 95010 and 95015 based on a typical patient that requires venom testing, but determined that both codes were reported on the same day by the same physician more than 80% of time and that a new bundled code was appropriate. As part of the process to develop a bundled code, the specialty society determined there to be little difference in physician work between percutaneous and intracutaneous testing on a "per test" basis, but a significant difference in practice expense inputs and typical number of tests required when comparing venom testing to drugs/biologic testing. Based on this information, the CPT Editorial Panel approved two new bundled codes, one code for percutaneous/intracutaneous venom testing and one code for percutaneous/intracutaneous drug/biologic testing. RUC surveys were conducted for each new code, using the typical patient and typical total number of tests required. The work RVU and times approved by the RUC would then be divided by the typical number of tests to determine the "per test" values.

95017 ***Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests***
At the April 2011 RUC meeting CPT codes 95010 and 95015 (subsequently deleted) were thought to typically be billed with an Evaluation and Management service on the same day and at that time the RUC determined that pre- and post- time should be reduced from the recommended survey times. However, upon further review of claims data, the RUC determined that code 95017 is not typically reported on the same day as an E/M and therefore E/M time and work is bundled into the pre and post-work. The RUC reviewed the survey results from 72 allergists for CPT code 95017 and determined that the median pre-, intra-, and post-times (15, 20, 15, respectively) and the median work RVU of 1.80 are appropriate for the total physician work required for the typical patient who would have 27 venom tests. The RUC compared 95017 to key reference CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family* (work RVU=2.43) and 95017 to MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity.*

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Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family (work RVU=1.42) and determined that the survey median work RVU of 1.80 appropriately placed 95017 between these two references. The RUC also compared 95017 to CPT code 95808 *Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist* (work RVU=1.74) and noted that this service has identical time with 15 minutes pre-service time, 20 minutes intra-service time and 15 minutes post-service time, and required slightly less intensity to perform, justifying the slightly higher work RVU for 95017. The approved total work RVU of 1.80 for the typical patient was divided by the typical number of tests (27) to arrive at 0.07 work RVUs "per test." The approved total pre-, intra-, and post-times (15, 20, 15, respectively) were divided by the typical number of tests (27) to arrive at the "per test" pre-, intra-, and post-times (0.556, 0.741, 0.556, respectively). This calculation allows for correct work valuation for the typical patient who will undergo 27 venom tests. **The RUC recommends a work RVU of 0.07 per test for CPT code 95017**.

95018 ***Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report by a physician, specify number of tests***
At the April 2011 RUC meeting CPT codes 95010 and 95015 (subsequently deleted) were thought to typically be billed with an Evaluation and Management service on the same day and at that time the RUC determined that pre- and post- time should be reduced from the recommended survey times. However, upon further review of claims data, the RUC determined that code 95018 is not typically reported on the same day as an E/M and therefore E/M time and work is bundled into the pre and post-work. The RUC reviewed the survey results from 69 allergists for CPT code 95018 and determined that the median pre-, intra-, and post-times (15, 15, 15, respectively) and the 25th percentile work RVU of 1.25 are appropriate for the total physician work required for the typical patient who would have 9 drug tests. The RUC compared 95018 with key reference CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family* (work RVU=1.50) and CPT code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=0.97) and determined that the survey 25th percentile work RVU of 1.25 appropriately placed 95018 between these two references. The RUC also compared 95018 to CPT code 93284 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system* (work RVU=1.25) and noted that this service requires the same intra-service time of 15 minutes and would require the same total physician work. The approved total work RVU of 1.25 for the typical patient was divided by the typical number of tests (9) to arrive at 0.14 work RVUs "per test." The approved total pre-, intra-, and post-times (15, 15, 15, respectively) were divided by the typical number of tests (9) to arrive at the "per test" pre-, intra-, and post-times (1.667, 1.667, 1.667, respectively). This calculation allows for correct work valuation for the typical patient who will undergo 9 drug tests. **The RUC recommends a work RVU of 0.14 per test for CPT code 95018**.

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Work Neutrality
The RUC's recommendations for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D95010		~~Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests~~	XXX	N/A
D95015		~~Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests~~ (95010 and 95015 have been deleted. To report, see 95017 and 95018)	XXX	N/A
●95017	EE1	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.07
●95018	EE2	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.14

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95017 Tracking Number EE1 Original Specialty Recommended RVU: **0.07**
Presented Recommended RVU: **0.07**
Global Period: XXX RUC Recommended RVU: **0.07**

CPT Descriptor: Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old male with a history of being stung by an insect followed by generalized urticaria and mild chest discomfort requires venom allergy testing. The allergist performs 27 total tests that include percutaneous and intracutaneous tests of venoms and appropriate positive and negative controls.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: An updated medication history is obtained, along with a review of pertinent medical problems that may have arisen since the previous visit. Explain procedure to patient/family and review risks and complications, including the possibility of anaphylaxis. Obtain consent. Verify that all required supplies and equipment are available, both for testing and for possible intervention if a reaction occurs. Based on evaluation of patient history and risk factors, a safe starting dose is determined and instructions are provided to clinical staff for preparation of testing dilutions.

Description of Intra-Service Work: The first test includes five percutaneous venom tests and two percutaneous control tests (positive histamine and negative diluent). After 15-20 minutes, the physician interprets this initial test by viewing skin reaction at venom test sites compared to control sites and determines if intracutaneous testing can proceed. Sequential and incremental intracutaneous testing is performed in four batches of five venoms. Fifteen to 20 minutes after each test, the physician interprets this test by viewing skin reaction at venom test sites compared to control sites. The physician is available in the office for entire intra-service period and checks the patient periodically and before administration of each test for local and systemic reactions.

Description of Post-Service Work: Discuss testing results with patient/family. Discuss possibility of delayed reaction. Make sure the patient understands how to recognize a reaction and what to do if a reaction occurs, including proper use of EpiPen and/or oral medication. Discuss future management of the condition. Dictate testing results and complete medical record documentation. Discuss results with referring physician and/or PCP (verbal and written)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Gary Gross, MD; Donald Aaronson, MD; Jacqueline Pongracic, MD				
Specialty(s):	allergy/immunology				
CPT Code:	95017				
Sample Size:	346	**Resp N:**	72	**Response:** 20.8 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	18.00	162.00
Survey RVW:	0.40	0.90	**1.80**	2.43	4.10
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	10.00	**20.00**	30.00	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95017	**Recommended Physician Work RVU: 0.07**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.56**	**0.00**	**0.56**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**0.74**		

Immediate Post Service-Time:	**0.56**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.43	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.42	**RUC Time**	9,033,717

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92004	XXX	1.82	**RUC Time**	2,123,579

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 26.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 95017**	**Key Reference CPT Code:** 99204	**Source of Time** **RUC Time**
Median Pre-Service Time	0.56	0.18	
Median Intra-Service Time	0.74	1.11	
Median Immediate Post-service Time	0.56	0.37	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**1.86**	**1.66**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.88
Urgency of medical decision making	4.21	3.53
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.58	3.06
Physical effort required	2.83	2.76
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.37	3.53
Outcome depends on the skill and judgment of physician	4.37	3.76
Estimated risk of malpractice suit with poor outcome	4.53	3.59

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.79	3.53
Intra-Service intensity/complexity	3.58	3.65
Post-Service intensity/complexity	4.00	3.82

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

In the Medicare Physician Payment Schedule Proposed Rule and Final Rule for 2011, CMS indicated that they believe services with low work RVUs that are commonly billed with multiple units in a single encounter are an additional appropriate category for identifying potentially misvalued codes (ie, low value-billed in multiple units screen). CMS requested that the RUC review specific codes, including codes **95010** *Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests* and **95015** *Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests.* "

JCAAI conducted RUC surveys for codes 95010 and 95015 and presented work RVU recommendations at the April 2011 RUC meeting. At that meeting, it was determined that 95010 and 95015 were reported on the same day by the same physician more than 80% of time. Based on this information, the RUC asked the specialty to pursue a new bundled code.

During development of the coding change proposal, JCAAI determined that although there was little difference in "per test" physician work between percutaneous and intracutaneous testing, there was a difference in direct practice expense inputs when comparing venoms to drugs/biologics. There also was a difference in the typical number of tests required for venom testing when compared with drug/biologic testing. This information resulted in a request for two new bundled codes: one code for percutaneous/intracutaneous venom testing; and one code for percutaneous/intracutaneous drug/biologic testing.

Survey Sample

A RUC survey was sent to a random sample of JCAAI members. An email query was sent to all JCAAI members asking for volunteers who perform either venom or drug/biologic testing allergy testing and who would be willing and available to participate in a review of physician work during the February/March survey time frame. In addition, JCAAI conducted a Webinar for any participant interested in learning more about the RUC survey process. A power point presentation (approved by RUC staff) was used in the Webinar and the Webinar was attended by RUC staff. The power point presentation was the standard RUC process power point presentation, modified to accommodate codes with an XXX global period instead of a 90-day global period.

Survey Vignette

The vignette for new code 95017 bundles the vignettes of to-be-deleted codes 95010 (7 percutaneous venom tests) plus 95015 (20 intracutaneous venom tests). These numbers of tests were previously determined to be typical for each code.

Recommendation for Pre-, Intra- and Post-time

During the previous review of codes 95010 and 95015 at the April 2011 meeting, a table was provided that indicated an EM was typically billed with these codes on the same day. April 2011 Information:

CPT	Est 2010 Util	2009 Util	5% file of 2009 Util Used	% Billed with Office E/M
95010	108,095	118,160	5,352	**84%**
95015	57,772	46,551	2,388	**54%**

Based on this table, the RUC determined that pre- and post-time should be reduced from the recommended survey times. *"The specialty society indicated and the RUC agreed that this service is typically reported with an Evaluation and Management service on the same date by the same provider as part of counseling the patient on the use of the epinephrine auto injector following the tests. Therefore, the RUC reduced the pre-service time to 7 minutes and reduced the immediate post-service time to 2 minutes."*

At this April 2012 meeting, a new table that reviewed the same 5% file indicates that the previous table had an error. April 2012 Information:

CPT	2010 Util	2009 Util	5% file of 2009 Util Used	% Billed with Office E/M
95010	80,259	118,160	233	**4%**
95015	56,202	46,551	123	**5%**

This corrected data is not surprising considering that only a *significant* and *separately identifiable* E/M service can be reported (mod-25 appended) in conjunction with these codes. **We recommend the survey median times for pre, intra, and post work divided by 27 for "per test" minutes as shown below.**

CPT	DESC	Total Time	pre	intra	post
95017	Total for 27 Tests	50	15	20	15
95017	**Total divided by 27 = PER TEST**	**1.852**	**0.556**	**0.741**	**0.556**

Work RVU Recommendation

As shown in the table below, the 2012 current work RVUs for codes 95010 and 95015 result in a blended work RVU of 0.07 per test [Row 7: (95010 * 7 * 0.11) + (95015 * 20 * 0.06) divided by 27 = 0.07].

The survey median work RVU of 1.80 corresponds to physician work for 27 venom tests. Dividing this work RVU of 1.80 by 27 tests results in a per test work RVU of 0.07.

We recommend a work RVU of 0.07 per test for 95017. This value is over 50% less than the 2011 work RVU of 0.15 for 95010 and 95015. This value is the same as the per test value based on the RUC's previous determination for venom allergy testing (April 2011).

		CPT	DESC	IWPUT	RVW	Total Time	pre	intra	post
1	**REF**	**99204**	OV, new patient - LEVEL 4	**0.070**	**2.43**	**45**	5	30	10
3		95010	RUC approved for 7 VENOM tests (after time deleted for EM)	0.057	0.77	19	7	10	2
4	***per test =***	**95010**	**Percutaneous tests**	**0.057**	**0.11**	**2.72**	**1.00**	**1.43**	**0.29**
5		95015	RUC approved for 20 VENOM tests (after time deleted for EM)	0.065	1.20	25	7	15	3
6	***per test =***	**95015**	**Intracutaneous**	**0.065**	**0.06**	**1.25**	**0.35**	**0.75**	**0.15**
7	**CURRENT**	**(95010 * 7) + (95015 * 20) divided by 27**		**0.062**	**0.07**	**1.631**	**0.519**	**0.926**	**0.186**
8	**SVY**	**95017**	Allergy testing, any combination…	**0.056**	**1.80**	**50**	**15**	**20**	**15**
9	**REC**		**Totals for 27 Tests**	**0.056**	**1.80**	**50**	**15**	**20**	**15**
10	**REC**		**Total divided by 27 = PER TEST**	**0.056**	**0.07**	**1.852**	**0.556**	**0.741**	**0.556**

The recommended work RVU of 0.07 per test (1.80 for 27 typical tests) is supported by comparison with the key reference code, MPC codes, and several other RUC reviewed XXX-global codes requiring similar total physician work.

Key Reference Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2006	99204	OV, new patient - LEVEL 4 (45 minutes face-to-face)	2.43	0.070	45	5	30	10
2006	99204	OV, new patient - LEVEL 4 divided by 27	0.09	0.070	1.67	0.19	1.11	0.37
2012	***95017***	***Perc plus intracut venom testing – 27 tests***	***1.80***	***0.056***	***50***	***15***	***20***	***15***
2012	*95017*	*Perc plus intracut venom testing – per test*	*0.07*	*0.056*	*1.85*	*0.56*	*0.74*	*0.56*

MPC Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2006	99203	OV new pt - LEVEL 3 (30 min face-to-face)	1.42	0.061	29	4	20	5
2012	***95017***	***Perc plus intracut venom testing – 27 tests***	***1.80***	***0.056***	***50***	***15***	***20***	***15***
2012	*95017*	*Perc plus intracut venom testing – per test*	*0.07*	*0.056*	*1.85*	*0.56*	*0.74*	*0.56*
2007	**92004**	Eye exam new patient	1.82	0.059	40	5	25	10

Other Code Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2010	**95808**	Polysomnography 1-3	1.74	0.053	50	15	20	15
2009	**75572**	CT hrt w/3d image	1.75	0.065	40	10	20	10
2008	**93351**	Stress tte complete	1.75	0.071	35	5	20	10
2011	**99395**	Prev visit est age 18-39	1.75	0.061	35	5	25	5
2012	***95017***	***Perc plus intracut venom testing – 27 tests***	***1.80***	***0.056***	***50***	***15***	***20***	***15***
2012	*95017*	*Perc plus intracut venom testing – per test*	*0.07*	*0.056*	*1.85*	*0.56*	*0.74*	*0.56*
2007	**92004**	Eye exam new patient	1.82	0.059	40	5	25	10
2002	**92616**	Fees w/laryngeal sense test	1.88	0.057	45	10	25	10
2006	**99243**	Office consultation	1.88	0.058	40	5	28	7
2011	**99384**	Prev visit new age 12-17	2.00	0.067	40	8	25	7

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95010 plus 95015

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty allergy/immunology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 102,346 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2010 data: 75% of 95010 plus 95015 (to be deleted)

Specialty allergy/immunology Frequency 54510 Percentage 53.26 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95010

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95018 Tracking Number EE2 Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.17**
Global Period: XXX RUC Recommended RVU: **0.14**

CPT Descriptor: Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old woman with chronic sinusitis and a history of adverse reactions to multiple antibiotics requires drug allergy testing. The allergist performs 9 total tests that include percutaneous and intracutaneous tests of penicillin and appropriate positive and negative controls.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: An updated medication history is obtained, along with a review of pertinent medical problems that may have arisen since the previous visit. Explain procedure to patient and review risks and complications, including the possibility of anaphylaxis. Obtain consent. Verify that all required supplies and equipment are available, both for testing and for possible intervention if a reaction occurs. Based on evaluation of patient history and risk factors, a safe starting dose is determined and instructions are provided to clinical staff for preparation of testing dilutions.

Description of Intra-Service Work: The first test includes four percutaneous tests, including benzylpenicilloyl polylysine, penicillin G potassium, and two control tests (positive histamine and negative diluent). After 15-20 minutes, the physician interprets this initial test by viewing skin reaction at drug test sites compared to control test sites and determines intracutaneous testing should proceed. Next, intracutaneous testing is performed that includes five tests; benzylpenicilloyl polylysine in duplicate, penicillin G potassium in duplicate, and one negative control test (diluent). After 15-20 minutes, the physician interprets the test by viewing skin reaction at drug test sites compared to control test sites. The physician is available in the office for entire intra-service period and checks the patient periodically and before administration of each test for local and systemic reactions.

Description of Post-Service Work: Discuss testing results with patient/family. Discuss possibility of delayed reaction. Make sure the patient understands how to recognize a reaction and what to do if a reaction occurs, including proper use of EpiPen and/or oral medication. Discuss future management of the condition. Dictate testing results and complete medical record documentation. Discuss results with referring physician and/or PCP (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Gary Gross, MD; Donald Aaronson, MD; Jacqueline Pongracic, MD				
Specialty(s):	allergy/immunology				
CPT Code:	95018				
Sample Size:	346	**Resp N:**	69	**Response:** 19.9 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	6.00	**15.00**	40.00	200.00
Survey RVW:	0.48	1.25	**1.80**	2.43	3.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	30.00	70.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95018	**Recommended Physician Work RVU: 0.14**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.67**	**0.00**	**1.67**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**1.67**		

Immediate Post Service-Time:	**1.67**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	0.00	**RUC Time**	9,033,717

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92004	XXX	0.00	**RUC Time**	2,123,579

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 28.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 95018**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	1.67	0.56	
Median Intra-Service Time	1.67	2.78	
Median Immediate Post-service Time	1.67	1.11	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**5.01**	**4.45**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.15	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.41
Urgency of medical decision making	4.00	3.35
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.55	3.18
Physical effort required	2.95	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.25	3.65
Outcome depends on the skill and judgment of physician	4.30	3.76
Estimated risk of malpractice suit with poor outcome	4.45	3.94

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.24
Intra-Service intensity/complexity	3.50	3.06
Post-Service intensity/complexity	3.75	3.41

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

In the Medicare Physician Payment Schedule Proposed Rule and Final Rule for 2011, CMS indicated that they believe services with low work RVUs that are commonly billed with multiple units in a single encounter are an additional appropriate category for identifying potentially misvalued codes (ie, low value-billed in multiple units screen). CMS requested that the RUC review specific codes, including codes **95010** *Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests* and **95015** *Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests.* "

JCAAI conducted RUC surveys for codes 95010 and 95015 and presented work RVU recommendations at the April 2011 RUC meeting. At that meeting, it was determined that 95010 and 95015 were reported on the same day by the same physician more than 80% of time. Based on this information, the RUC asked the specialty to pursue a new bundled code.

During development of the coding change proposal, JCAAI determined that although there was little difference in "per test" physician work between percutaneous and intracutaneous testing, there was a difference in direct practice expense inputs when comparing venoms to drugs/biologics. There also was a difference in the typical number of tests required for venom testing when compared with drug/biologic testing. This information resulted in a request for two new bundled codes: one code for percutaneous/intracutaneous venom testing; and one code for percutaneous/intracutaneous drug/biologic testing.

Survey Sample

A RUC survey was sent to a random sample of JCAAI members. An email query was sent to all JCAAI members asking for volunteers who perform either venom or drug/biologic testing allergy testing and who would be willing and available to participate in a review of physician work during the February/March survey time frame. In addition, JCAAI conducted a Webinar for any participant interested in learning more about the RUC survey process. A power point presentation (approved by RUC staff) was used in the Webinar and the Webinar was attended by RUC staff. The power point presentation was the standard RUC process power point presentation, modified to accommodate codes with an XXX global period instead of a 90-day global period.

Survey Vignette

The vignette for new bundled code 95018 describes the typical number of tests (9) involved in penicillin allergy testing, the most common drug tested.

Compelling Evidence

The work RVUs for codes 95010 and 95015 were based on venom testing which represents 75-80 percent of patients. However, patients undergoing drug allergy testing require more physician time and work on a per test basis than venom testing because there are duplicate tests in each batch that add a degree to the complexity and additional time for assessment.

Consideration for the increased work of drug testing *may* have been incorporated in the original work RVUs for codes 95010 and 95015 (1993-2011 work RVU was 0.15 per test for both codes). However, the additional work for drug allergy testing was not considered in the April 2011 RUC review where the typical patient description for both 95010 and 95015 was venom allergy testing. Additionally, incorrect information regarding same day billing of an E/M service resulted in reduction of time.

At the April 2011 meeting, it was determined that 95010 and 95015 were reported on the same day by the same physician more than 80% of time and the specialty was asked to pursue a new bundled code. Instead of tabling the review of 95010 and 95015, the RUC forwarded recommendations to CMS for reduced work RVUs – based on venom allergy testing and same day E/M billing.

The current review of 95018 will be the first time that drug allergy testing will be separately reviewed. The work RVU we are requesting for 95018 is greater than 95017. If we could step back one year, the values we are recommending for

new bundled codes 95017 and 95018 would show significant savings to Medicare AND represent correct relativity between per test venom and per test drug allergy testing.

Savings based on 2011 work RVUs compared with 2012 work RVUs:

CPT	2010 Util	2011 RVW	total RVWs
95010	80,259	0.15	12,039
95015	56,202	0.15	8,430
	136,461		**20,469**
CPT	**2010 Util**	**2012 RVW**	**total RVWs**
95010	80,259	0.11	8,828
95015	56,202	0.06	3,372
	136,461		**12,201**
			(8,269)

Savings based on 2011 work RVUs compared with current recommendations:.

CPT		2010 Util	2011 RVW	total RVWs
95010		80,259	0.15	12,039
95015		56,202	0.15	8,430
		136,461		**20,469**
CPT	**Util Split***	**2010 Util**	**Rec RVW**	**total RVWs**
X1 venom	**0.75**	102,346	0.07	7,164
X2 drug	**0.25**	34,115	0.17	5,800
		136,461		**12,964**
				(7,505)

* Estimated national percentage split of new bundled venom vs drug from the total utilization of 95010 and 95015 which were reported per test. The venom percentage is much higher because of the typical number of tests (27 vs 9 or 3:1 or 75:25). This estimated split in confirmed by the expert panel reviewing these data.

The difference in savings between the 2011 RUC review of 95010 and 95015 and current recommendations for new bundled codes 95017 and 95018 equates to approximation $29,000. We believe that if the RUC had requested bundling of codes 95010 and 95015 prior to making a recommendation to CMS, we would not have had to present compelling evidence because the recommendations for the new bundled codes represent significant savings to Medicare (-7,505 work RVUs).

We ask the RUC to consider this discussion regarding the premature review and incorrect E/M assumptions as compelling evidence to consider a different work RVU for 95018.

Pre-, Intra- and Post-time Recommendation

During the previous review of codes 95010 and 95015 at the April 2011 meeting, a table was provided that indicated an EM was typically billed with these codes on the same day. April 2011 Information:

CPT	*Est* 2010 Util	2009 Util	5% file of 2009 Util Used	% Billed with Office E/M
95010	108,095	118,160	5,352	**84%**
95015	57,772	46,551	2,388	**54%**

Based on this table, the RUC determined that pre- and post-time should be reduced from the recommended survey times. *"The specialty society indicated and the RUC agreed that this service is typically reported with an Evaluation and Management service on the same date by the same provider as part of counseling the patient on the use of the epinephrine auto injector following the tests. Therefore, the RUC reduced the pre-service time to 7 minutes and reduced the immediate post-service time to 2 minutes."*

At this April 2012 meeting, a new table that reviewed the same 5% file indicates that the previous table had an error. April 2012 Information:

CPT	2010 Util	2009 Util	5% file of 2009 Util Used	% Billed with Office E/M
95010	80,259	118,160	233	**4%**
95015	56,202	46,551	123	**5%**

This corrected data is not surprising considering that only a *significant* and *separately identifiable* E/M service can be reported (mod-25 appended) in conjunction with these codes. **We recommend the survey median times for pre, intra, and post work divided by 9 for "per test" minutes as shown below.**

CPT	DESC	Total Time	pre	intra	post
95018	Total for 9 Tests	45	15	15	15
95018	Total divided by 9 = PER TEST	5.000	1.667	1.667	1.667

Work RVU Recommendation

We recommend a per test work RVU of 0.14 for 95018. This per test value is greater than the 2011 work RVU of 0.15 for 95010 and 95015, which included both drug and venom allergy testing. Taken together with the per test recommendation of 0.07 work RVUs for new bundled code 95017, this recommendation accounts for the difference in physician work for venom and drug allergy testing that has previously not been considered and represents a significant overall savings due to bundling.

The per test work RVU of 0.17 is supported by comparison with the key reference code, MPC codes, and several other RUC reviewed XXX-global codes requiring similar total physician work.

Key Reference Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2006	99214	OV, estab patient - LEVEL 4 (25 minutes face-to-face)	1.50	0.047	40	5	25	10
2006	99214	OV, estab patient - LEVEL 4 divided by 9	0.17	0.047	4.44	0.56	2.78	1.11
2012	***95018***	***Perc plus intracut drug testing – 9 tests***	***1.50***	***0.055***	***45***	***15***	***15***	***15***
2012	*95018*	*Perc plus intracut venom testing – per test*	*0.17*	*0.055*	*5.00*	*1.67*	*1.67*	*1.67*

MPC Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2006	99203	OV new pt - LEVEL 3 (30 min face-to-face)	1.42	0.061	29	4	20	5
2012	***95018***	***Perc plus intracut drug testing – 9 tests***	***1.50***	***0.055***	***45***	***15***	***15***	***15***
2012	*95018*	*Perc plus intracut venom testing – per test*	*0.17*	*0.055*	*5.00*	*1.67*	*1.67*	*1.67*
2007	**92004**	Eye exam new patient	1.82	0.059	40	5	25	10

Other Code Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2008	**93284**	Icd device progr eval mult	1.25	0.056	34	9	15	10
2011	**99391**	Periodic preventive reeval est pat inf	1.37	0.069	26	4	17	5
2009	**78451**	Ht muscle image spect sing	1.38	0.062	35	10	15	10
2008	**93350**	Stress tte only	1.46	0.064	28	3	20	5
2012	***95018***	***Perc plus intracut drug testing – 9 tests***	***1.50***	***0.055***	***45***	***15***	***15***	***15***
2012	*95018*	*Perc plus intracut venom testing – per test*	*0.17*	*0.055*	*5.00*	*1.67*	*1.67*	*1.67*
2010	**95808**	Polysomnography 1-3	1.74	0.053	50	15	20	15
2009	**75572**	CT hrt w/3d image	1.75	0.065	40	10	20	10
2008	**93351**	Stress tte complete	1.75	0.071	35	5	20	10
2004	**79005**	Nuclear rx oral admin	1.80	0.075	45	20	15	10

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95010 plus 95015

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty allergy/immunology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 34,115 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2010 data: 25% of 95010 plus 95015 (to be deleted)

Specialty allergy/immunology Frequency 18170 Percentage 53.26 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95010

SS Rec Summary

ISSUE: Percutaneous / Intracutaneous Allergy Testing

TAB: 29

SOURCE	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	POST P-SD
REF	**99204**	OV, new patient - LEVEL 4 (45 minutes face-to-face)	19	**0.070**			**2.43**			**45**	5			30			10
	95010	RUC approved for venom 7 tests (after time deleted for EM)		0.057			0.77			19	7			10			2
per test	**95010**	**Percutaneous tests (scratch, puncture, prick) sequential and**		**0.057**			**0.11**			**2.72**	**1.00**			**1.43**			**0.29**
	95015	RUC approved for 20 venom tests (after time deleted for EM)		0.065			1.20			25	7			15			3
per test	**95015**	**Intracutaneous (intradermal) tests, sequential and incrementa**		**0.065**			**0.06**			**1.25**	**0.35**			**0.75**			**0.15**
CURRENT	**(95010 * 7) + (95015 * 20) divided by 27**			**0.062**			**0.07**			**1.631**	**0.519**			**0.926**			**0.186**
SVY	**95017**	VENOM - Allergy testing, any combination of percutaneous (scrat	**72**	**0.056**	**0.40**	**0.90**	**1.80**	**2.43**	**4.10**	**50**	**15**	**10**	**10**	**20**	**30**	**120**	**15**
	95017	**Totals for 27 Tests**		**0.056**			**1.80**			**50**	**15**			**20**			**15**
PER TEST	**95017**	**Total divided by 27 = PER TEST**		**0.056**			**0.07**			**1.852**	**0.556**			**0.741**			**0.556**

SOURCE	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	POST P-SD
REF	**99214**	OV, established pt - LEVEL 4	20	**0.047**			**1.50**			**40**	5			25			10
	95010	RUC approved for 7 tests (after time deleted for EM)		0.057			0.77			19	7			10			2
per test	**95010**	**Percutaneous tests (scratch, puncture, prick) sequential and**		**0.057**			**0.11**			**2.72**	**1.00**			**1.43**			**0.29**
	95015	RUC approved for 20 tests (after time deleted for EM)		0.065			1.20			25	7			15			3
per test	**95015**	**Intracutaneous (intradermal) tests, sequential and incrementa**		**0.065**			**0.06**			**1.25**	**0.35**			**0.75**			**0.15**
CURRENT	**(95010 * 4) + (95015 * 5) divided by 9**			**0.060**			**0.08**			**1.903**	**0.639**			**1.052**			**0.212**
SVY	**95018**	DRUG - Allergy testing, any combination of percutaneous (scratch	**69**	**0.068**	**0.48**	**1.25**	**1.80**	**2.43**	**3.00**	**50**	**20**	**5**	**10**	**15**	**30**	**70**	**15**
	95018	**Totals for 9 Tests**		**0.055**			**1.50**			**45**	**15**			**15**			**15**
PER TEST	**95018**	**Total divided by 9 = PER TEST**		**0.055**			**0.17**			**5.000**	**1.667**			**1.667**			**1.667**

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95017 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with **venoms**, immediate type reaction, including test interpretation and report by a physician, specify number of tests

Global Period XXX **Meeting Date**: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of allergists familiar with this new code met by conference call to discuss direct practice expense details.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:
Codes 95010 and 95015 will be deleted for 2013 and replaced by new bundled codes 95017 and 95018. The direct practice expense details of the to-be-deleted codes were considered when the recommendations for new code 95017 were discussed by the expert panel. – No inputs recommended for facility.

Please describe in detail the clinical activities of your staff:
Pre-Service Clinical Labor Activities:
N/A

Service Clinical Labor Activities:

	27 tests	per test	
Greet patient, provide gowning, ensure appropriate medical records are available	**3**	**0.111**	**Std Time** - Test in NOT typically performed with E/M.
Obtain vital signs	**3**	**0.111**	**Std time for 1-3 vitals**: BP, HR, RR
Provide pre-service education/obtain consent	**3**	**0.111**	This will be the first time a patient undergoes testing. An explanation of the testing and consent is necessary.
Prepare room, equipment, supplies			
Prepare testing board and testing syringes	**40**	**1.481**	**Previously approved total time for 95010 and 95015.** There is no overlap in preparation of percutaneous testing board and intradermal syringes. This includes documentation of expiration dates, lot numbers, etc. in the patient's chart.
Performing procedure (percut and intracut)	**33.5**	**1.241**	**Previously approved** 0.5 min per percutaneous plus 1.5 min per intradermal (0.5x7 + 1.5x20 = 33.5 min)
Monitor pt. following service/check tubes, monitors, drains	**21**	**0.778**	**Previously approved total time** for 95010 and 95015 - monitoring time approved for 27 tests.
Clean room/equipment by physician staff	**1**	**0.037**	Although testing supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office (eg, clean exam table and surfaces, dispose of table paper and gown)
Other Clinical Activity - *specify:* Charting	**6.75**	**0.250**	Each test site is measured (wheal and flare) and documented after the monitoring period @ 15 seconds per test.

Post-Service Clinical Labor Activities:
N/A

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95018 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with **drugs** or biologicals, immediate type reaction, including test interpretation and report by a physician, specify number of tests

Global Period XXX **Meeting Date**: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of allergists familiar with this new code met by conference call to discuss direct practice expense details.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:
Codes 95010 and 95015 will be deleted for 2013 and replaced by new bundled codes 95017 and 95018. The direct practice expense details of the to-be-deleted codes were considered when the recommendations for new code 95018 were discussed by the expert panel. – No inputs recommended for facility.

Please describe in detail the clinical activities of your staff:
Pre-Service Clinical Labor Activities:
N/A

Service Clinical Labor Activities:

	9 tests	per test	
Greet patient, provide gowning, ensure appropriate medical records are available	**3**	**0.333**	**Std Time** - Test is NOT typically performed with E/M.
Obtain vital signs	**3**	**0.333**	**Std time for 1-3 vitals**: BP, HR, RR
Provide pre-service education/obtain consent	**3**	**0.333**	This will be the first time a patient undergoes testing. An explanation of the testing and consent is necessary.
Prepare testing board and testing syringes	**13.33**	**1.481**	**Previously approved average** time for venom prep (40 min / 27 tests = 1.481 min/test). There is no overlap in preparation of percutaneous testing board and intradermal syringes. This work includes documentation of expiration dates, lot numbers, etc. in the patient's chart.
Assist physician in performing procedure	**9.50**	**1.056**	**Previously approved** 0.5 min per percutaneous plus 1.5 min per intradermal (0.5 x4 + 1.5x5 = 9.5 min)
Monitor pt. following service/check tubes, monitors, drains	**11.67**	**1.297**	Two "batches" of testing is performed. The patient is monitored for 15-20 minutes after each test (30-40 min). Clinical staff will typical monitor 1 to 2 patients. Recommend 1/3 of 35 min = 11.67.
Clean room/equipment by physician staff	**1**	**0.111**	Although testing supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office (eg, clean exam table and surfaces, dispose of table paper and gown)
Other Clinical Activity - *specify:* Charting	**2.25**	**0.250**	Each test site is measured (wheal and flare) and documented after the monitoring period @ 15 seconds per test.

Post-Service Clinical Labor Activities:
N/A

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE PEAC Apr 2011			REFERENCE CODE PEAC Apr 2011						
2				95010			95015			95017			
3	**Meeting Date: April 2012** **Tab: 29** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	**BASED ON "typical" 7 TESTS - Percutaneous** tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or			**BASED ON "typical" 20 TESTS - Intracutaneous** (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms,			**Venom - BASED ON "typical" 27 TESTS** **(7 scratch, 20 ID)** Allergy testing, any combination of percutaneous			**Notes**
4	**LOCATION**			**Office**		**FAC**	**Office**		**FAC**	**Office**		**FAC**	
5	**GLOBAL PERIOD**			**XXX**		**XXX**	**XXX**		**XXX**	**XXX**		**XXX**	
6				**per test**	**7 tests**		**per test**	**20 tests**		**per test**	**27 tests**		
7	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**4.572**		**N/A**	**3.611**		**N/A**	**4.120**		**N/A**	
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**		**0**	**0**		**0**	
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**4.572**	**32.0**	**0**	**3.611**	**72.2**	**0**	**4.120**	**111.3**	**0**	
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**		**0**	**0**		**0**	
11	**PRE-SERVICE**												
12	**Start: Following visit when decision for surgery or procedure made**												
19	**End: When patient enters office/facility for surgery/procedure**												
20	**SERVICE PERIOD**												
21	**Start: When patient enters office/facility for surgery/procedure:**												
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA							**0.111**	**3**		**Std Time** - Test in NOT typically performed with E/M.
23	Obtain vital signs	L037D	RN/LPN/MTA							**0.111**	**3**		**Std time for 1-3 vitals**: BP, HR
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA							**0.111**	**3**		This will be the first time a patient undergoes testing. An explanation of the testing and consent is necessary.
25	Prepare room, equipment, supplies												
27	Prepare testing board and testing syringes	L037D	RN/LPN/MTA	**2.143**	**15.0**		**1.250**	**25.0**		**1.481**	**40**		**Previously approved total time for 95010 and 95015.** There is no overlap in preparation of percutaneous testing board and intradermal syringes. This includes documentation of expiration dates, lot numbers, etc. in the patient's chart.
30	**Intra-service**												
31	Performing procedure (percut and intracut)	L037D	RN/LPN/MTA	**0.500**	**3.5**		**1.500**	**30.0**		**1.241**	**33.5**		**Previously approved** 0.5 min per percutaneous plus 1.5 min per intradermal (0.5x7 + 1.5x20 = 33.5 min)
32	**Post-Service**												
33	**Monitor pt**. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**1.500**	**10.5**		**0.525**	**10.5**		**0.778**	**21**		**Previously approved total time** for 95010 and 95015 - monitoring time approved for 27 tests.
34	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**0.143**	**1.0**		**0.050**	**1.0**		**0.037**	**1**		Although testing supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office (eg, clean exam table and surfaces, dispose of table paper and gown)
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
40	Other Clinical Activity - *specify:* Charting	L037D	RN/LPN/MTA	**0.286**	**2.0**		**0.286**	**5.7**		**0.250**	**6.75**		Each test site is measured (wheal and flare) and documented after the monitoring period @ 15 seconds per test.
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
56	**End: with last office visit before end of global period**												

	A	B	C	D	E	F	G	H	I	J	K	L	M
2				95010			95015			95017			
3	**Meeting Date: April 2012** **Tab: 29** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	**BASED ON "typical" 7 TESTS - Percutaneous** tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or			**BASED ON "typical" 20 TESTS - Intracutaneous** (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms,			**Venom - BASED ON "typical" 27 TESTS** **(7 scratch, 20 ID)** Allergy testing, any combination of percutaneous			**Notes**
4	**LOCATION**			**Office**		**FAC**	**Office**		**FAC**	**Office**		**FAC**	
57	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
58	paper, exam table	SB036	foot							**0.259**	**7**		
59	gown, patient	SB026	item							**0.037**	**1**		
60	~~drape, non-sterile, sheet 40in x 60in~~	~~SB006~~	~~item~~				**~~0.050~~**	**~~1.0~~**					
61	gloves, non-sterile	SB022	pair	**0.286**	**2.0**		**0.200**	**4.0**		**0.222**	**6**		one pair for prep of testing board, and one pair per administration of each batch.
62	~~gauze, non-sterile 2in x 2in~~	~~SG050~~	~~item~~	**~~0.286~~**	**~~2.0~~**		**~~0.140~~**	**~~2.8~~**					
63	swab-pad, alcohol	SJ053	item	**3.000**	**21.0**		**1.400**	**28.0**		**1.370**	**37**		5 pads for cleaning arm (5 batches). 7 for dilutions. 20 before drawing from 20 vials into syringes. 5 before drawing scratch amount into syringes.
64	~~antigen, venom~~	~~SH009~~	~~ml~~	**~~0.071~~**	**~~0.5~~**		**~~0.025~~**	**~~0.5~~**					
65	kit, antigen, venom (incl. five insect venoms)	NEW	kit							**0.037**	**1**		One single use kit will be used for testing session.
66	albumin saline	SH004	ml	**5.000**	**35.0**					**1.296**	**35**		Previously calculated: 1.2 ml for initial dilution of freeze dried venoms plus 1.8 ml subsequent dilutions for each venom.
67	negative control (saline/diluent), allergy test	NEW	ml							**0.002**	**0.05**		1 drop: 20 drops per ml (1/20=0.05)
68	positive control (histamine), allergy test	NEW	ml							**0.002**	**0.05**		1 drop: 20 drops per ml (1/20=0.05)
69	color coded cap and vial (for antigen)	SL027	item	**1.000**	**7.0**		**1.000**	**20.0**		**0.741**	**20**		Four dilutions x five venoms prepared.
70	label, vial	SL198	item							**0.741**	**20**		Four dilutions x five venoms prepared.
71	~~label for microscope slides~~	~~SL085~~	~~item~~				**~~1.000~~**	**~~20.0~~**					
72	bifurcated needle or stylet	SC099	item	**1.000**	**7.0**					**0.259**	**7**		
73	needle, 18-27g	SC029	item				**1.200**	**24.0**		**1.222**	**33**		1 to add albumin to all empty vials. 1 per venom/control for dilutions (7). 20 for injection plus 5 for scratch. (1+7+25=33)
74	syringe 3ml	SC055	item							**0.296**	**8**		1 to add albumin to all vials, 1 per venom for dilutions (1+7=8)
75	syringe 1ml	SC052	item				**1.200**	**24.0**		**0.926**	**25**		20 for injection plus 5 for scratch
76	triamcinolone acetonide 0.1% cream	SH072	gm	**0.140**	**1.0**		**0.050**	**1.0**		**0.074**	**2**		
77	**EQUIPMENT**	**CODE**											
78	No Equipment	EZ007		**0.000**	**0.000**		**0.000**	**0.000**					
79	table, exam	EF023								**2.639**	**71.25**		Total service-period minus testing board prepartion
80	light, exam	EQ168								**2.639**	**71.25**		Total service-period minus testing board prepartion
81													
82	Venom Diagnostic Kit ($168.40) 1 vial each of freeze-dried venom/venom protein extracts, one vial each of honey bee, yellow jacket, yellow hornet, white faced hornet, and wasp. When reconstituted with 1.2 ml of diluent, each vial contains 100 µg/ml of venom/venom protein.												
83	[NEGATIVE SCRATCH] Skin Test Negative Control 50% Glycerin 5 mL scratch $ 25.40												
84	[POSITIVE SCRATCH] Histatrol® Positive Control Histamine GLY 1.0 mg/mL (Histamine Base) 5 mL scratch $ 86.40												

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE PEAC Apr 2011			REFERENCE CODE PEAC Apr 2011						
2				95010			95015			95018			
3	**Meeting Date: April 2012** **Tab: 29** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	**BASED ON "typical" 7 TESTS - Percutaneous** tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or			**BASED ON "typical" 20 TESTS - Intracutaneous** (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms			**Drug - BASED ON "typical" 9 TESTS (4 scratch, 5 ID)** Allergy testing, any			**Notes**
4	**LOCATION**			**Office**		**FAC**	**Office**		**FAC**	**Office**		**FAC**	
5	**GLOBAL PERIOD**			**XXX**		**XXX**	**XXX**		**XXX**	**XXX**		**XXX**	
6				**per test**	**7 tests**		**per test**	**20 tests**		**per test**	**9 tests**		
7	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**4.572**		**N/A**	**3.611**		**N/A**	**5.195**		**N/A**	
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**		**0**	**0**		**0**	
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**4.572**	**32.0**	**0**	**3.611**	**72.2**	**0**	**5.195**	**46.8**	**0**	
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**		**0**	**0**		**0**	
11	**PRE-SERVICE**												
12	**Start: Following visit when decision for surgery or procedure made**												
19	**End: When patient enters office/facility for surgery/procedure**												
20	**SERVICE PERIOD**												
21	**Start: When patient enters office/facility for surgery/procedure:**												
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA							**0.333**	**3**		**Std Time** - Test is NOT typically performed with E/M.
23	Obtain vital signs	L037D	RN/LPN/MTA							**0.333**	**3**		**Std time for 1-3 vitals**: BP, HR, RR
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA							**0.333**	**3**		This will be the first time a patient undergoes testing. An explanation of the testing and consent is necessary.
25	Prepare room, equipment, supplies												
26	Prepare testing board and testing syringes	L037D	RN/LPN/MTA	**2.143**	**15.0**		**1.250**	**25.0**		**1.481**	**13.33**		**Previously approved average** time for venom prep (40 min / 27 tests = 1.481 min/test). There is no overlap in preparation of percutaneous testing board and intradermal syringes. This work includes documentation of expiration dates, lot numbers, etc. in the patient's chart.
30	**Intra-service**												
31	Assist physician in performing procedure	L037D	RN/LPN/MTA	**0.500**	**3.5**		**1.500**	**30.0**		**1.056**	**9.50**		**Previously approved** 0.5 min per percutaneous plus 1.5 min per intradermal (0.5 x4 + 1.5x5 = 9.5 min)
32	**Post-Service**												
33	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**1.500**	**10.5**		**0.525**	**10.5**		**1.297**	**11.67**		Two "batches" of testing is performed. The patient is monitored for 15-20 minutes after each test (30-40 min). Clinical staff will typical monitor **1-3** patients. Recommend 1/3 of 35 min = 11.67.
34	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**0.143**	**1.0**		**0.050**	**1.0**		**0.111**	**1**		Although testing supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office (eg, clean exam table and surfaces, dispose of table paper and gown)
40	Other Clinical Activity - *specify:* Charting	L037D	RN/LPN/MTA	**0.286**	**2.0**		**0.286**	**5.7**		**0.250**	**2.25**		Each test site is measured (wheal and flare) and documented after the monitoring period @ 15 seconds per test.
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
56	**End: with last office visit before end of global period**												

	A	B	C	D	E	F	G	H	I	J	K	L	M
2				95010			95015			95018			
3	**Meeting Date: April 2012** **Tab: 29** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	**BASED ON "typical" 7 TESTS - Percutaneous** tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or			**BASED ON "typical" 20 TESTS - Intracutaneous** (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms			**Drug - BASED ON "typical" 9 TESTS (4 scratch, 5 ID)** Allergy testing, any			**Notes**
4	**LOCATION**			**Office**		**FAC**	**Office**		**FAC**	**Office**		**FAC**	
57	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
58	paper, exam table	SB036	foot							**0.778**	**7**		
59	gown, patient	SB026	item							**0.111**	**1**		
60	~~drape, non-sterile, sheet 40in x 60in~~	~~SB006~~	~~item~~				~~**0.050**~~	~~**1.0**~~					
61	gloves, non-sterile	SB022	pair	**0.286**	**2.0**		**0.200**	**4.0**		**0.333**	**3**		one pair for prep of testing board, and one pair per administration of each batch.
62	gauze, non-sterile 2in x 2in	SG050	item	**0.286**	**2.0**		**0.140**	**2.8**		**0.111**	**1**		protect while break ampule
63	swab-pad, alcohol	SJ053	item	**3.000**	**21.0**		**1.400**	**28.0**		**1.000**	**9**		2 pads for cleaning arm. 2 for dilutions. 5 before drawing from 4 vials into syringes.
64	benzylpenicilloyl polylysine (eg, PrePen) 0.25ml uou	NEW	item							**0.111**	**1**		One single use ampule used per testing session.
65	penicillin G potassium **(HCPCS J2540)**									**0**	**0**		This will be billed using HCPCS J-code
66	sodium chloride 0.9% inj (10ml uou)	SH066	item	**5.000**	**35.0**					**0.111**	**1**		For pen G dilution
67	negative control, allergy scratch test	NEW	ml							**0.006**	**0.05**		1 drop: 20 drops per ml (1/20=0.05)
68	positive control, allergy scratch test	NEW	ml							**0.006**	**0.05**		1 drop: 20 drops per ml (1/20=0.05)
69	negative control, allergy intradermal test	NEW	ml							**0.022**	**0.20**		
70	color coded cap and vial (for antigen)	SL027	item	**1.000**	**7.0**		**1.000**	**20.0**		**0.333**	**3**		2 for pen g dilutions, 1 for prepen transfer
71	label, vial	SL198	item							**0.333**	**3**		
72	~~label for microscope slides~~	~~SL085~~	~~item~~				~~**1.000**~~	~~**20.0**~~					
73	bifurcated needle or stylet	SC099	item	**1.000**	**7.0**					**0.444**	**4**		
74	needle, 18-19g, filter	SC027	item							**0.111**	**1**		to draw from PrePen ampule
75	syringe 3ml	SC055	item							**0.111**	**1**		to draw from PrePen ampule
76	needle, 18-27g	SC029	item				**1.200**	**24.0**		**0.556**	**5**		2 perc, 2 intraderm, 1 ID neg control
77	syringe 1ml	SC052	item				**1.200**	**24.0**		**0.556**	**5**		2 perc, 2 intraderm, 1 ID neg control
78	triamcinolone acetonide 0.1% cream	SH072	gm	**0.140**	**1.0**		**0.050**	**1.0**		**0.111**	**1**		
79	**EQUIPMENT**	**CODE**											
80	No Equipment	EZ007		**0.000**	**0.000**		**0.000**	**0.000**					
81	table, exam	EF023								**3.713**	**33.42**		Total service-period minus testing board prepartion
82	light, exam	EQ168								**3.713**	**33.42**		Total service-period minus testing board prepartion
83													
84	Pre-pen, one single use vial = $69.00												
85	[NEGATIVE SCRATCH] Skin Test Negative Control 50% Glycerin 5 mL scratch $ 25.40												
86	[POSITIVE SCRATCH] Histatrol® Positive Control Histamine GLY 1.0 mg/mL (Histamine Base) 5 mL scratch $ 86.40												
87	[NEGATIVE INTRADERMAL] Skin Test Negative Control Aqueous 5 mL intradermal $ 25.40												

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Allergen Ingestion Test

In 1995, the RUC reviewed CPT code 95075 *Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)* and recommended to maintain the 1993 work RVUs, which were not based on a RUC survey. The code has not been reviewed since 1995 and the RUC determined that the dominant specialty at that time (otolaryngology) is no longer the dominant specialty (currently, Allergy/Immunology). In February 2012, the CPT Editorial Panel deleted 95075 and created CPT code 95076 *Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing* and CPT code 95079 *Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure),* to establish time based codes to report ingestion challenge tests. The RUC agreed with the specialty society that there is compelling evidence to increase the value of these codes based on a change in the patient population and related physician work. The patient population and severity of food allergies is vastly different than it was in 1995. The 1995 typical patient reacted to wheat with nasal congestion symptoms in comparison to current population. Food allergies (most typically peanuts) now result in anaphylaxis and potentially death (ie, not just nasal congestion). Although not typical in the office setting during testing, anaphylaxis and death is a serious concern, requiring close monitoring by the physician throughout the testing period.

Medicare data indicate an E/M is typically performed on the same day. Although the specialty society experts could not be certain, they believe if a Medicare patient receives this test it would likely be for a speculative antibiotic allergy. These Medicare patients would not undergo incremental dosing and extended monitoring and moving forward would not likely report the new time based code. In addition, Medicare patients comprise a fraction of the national utilization of this code. The RUC agreed with the specialty society and the typical patient is a pediatric patient. A CPT Assistant article will be developed to explain that these codes are to be used to report incremental challenges that require monitoring between dosing and that anything less is to be reported with an Evaluation and Management Service.

95076

The RUC reviewed the survey results from 107 allergists and determined that the work RVU of 1.50, the survey's 25th percentile appropriately accounts for the physicians work required to perform this service. The RUC agreed with the survey times of 7 minutes pre-service, 30 minutes intra-service and 5 minutes post-service. The RUC compared 95076 to key reference CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=2.11) which has slightly less intra-service time at 30 and 35 minutes, respectively and less total time at 42 and 55 minutes, respectively. The RUC agreed with the specialty that 95076 requires less time and intensity to perform compared with 99215 and therefore should have a lower work RVU. The RUC also compared 95076 to a second reference code cited by the specialty, CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established* (work RVU=1.50) which

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has slightly less intra-time and almost identical total time. The RUC agreed that 95076 and 99214 would require similar total physician work and similar intensity, and therefore agreed with the specialty that the 25th percentile work RVU of 1.50 was appropriate. As additional support, the RUC compared 95076 to 99393 *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)* (work RVU=1.50), with identical physician work. **The RUC recommends a work RVU of 1.50 for CPT code 95076.**

95079

The RUC reviewed the survey results from 104 allergists and determined that the work RVU of 1.38, the survey's 25th percentile, appropriately accounts for the physicians work required to perform this service. The RUC agreed with the survey time of 30 minutes intra-service. The RUC compared 95079 to key reference CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=2.11) and determined 99215 required more work than 95079, but was not a good reference because of the difference in global period. The RUC determined 95079 should be compared to other codes which have a ZZZ-global, including 13102 *Repair, complex, trunk; each additional 5 cm or less* (work-RVU=1.24) and 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less* (work RVU=1.44). Codes 13102 and 13122 bracket code 95079 in time and support the 25th percentile work RVU of 1.38. The RUC also compared the surveyed service to CPT code 99355 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)* (work RVU=1.77) with identical intra-service time. **The RUC recommends a work RVU of 1.38 for CPT code 95079.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Medicine** **Allergy and Clinical Immunology**				
Definitions ***Immunotherapy (desensitization, hyposensitization)*** *is the parenteral administration of allergenic….* **Other therapy:** for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see **Evaluation and Management** services ~~section~~ Do not report Evaluation and Management (E/M) services for test interpretation and report. If a significant separately identifiable E/M service is performed, the appropriate E/M service code which may include office or other outpatient services (99201-99215), hospital observation services (99217-99220; 99224-99226), initial hospital care (99221-99233), subsequent hospital care and hospital discharge services (99231-99239), consultations (99241-99255), emergency department services (99281-99285), nursing facility services (99304-99316, 99318), domiciliary, rest home services (99324-99337), home services (99341-99350), preventive medicine services (99381-99397) should be reported using modifier 25.				
Ingestion Challenge Testing Codes 95076 and 95079 are used to report ingestion challenge testing. Report code 95076 for initial 120 minutes of *testing* time (ie, not physician face-to-face time). Report code 95079 for each additional 60 minutes of *testing* time (ie, not physician face-to-face time). For total *testing* time less than 61 minutes (eg, positive challenge resulting in cessation of testing), report Evaluation and Management service, if appropriate. Patient assessment/monitoring activities for allergic reaction (eg, blood pressure testing, peak flow meter testing) are not separately reported. Intervention therapy (eg, injection of steroid or epinephrine) may be reported separately as appropriate. For purposes of reporting testing times, if an evaluation and management service is required, then testing time ends.				

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D95075		~~Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)~~ (Code 95075 has been deleted. For ingestion challenge testing, see 95076-95079)	XXX	N/A
●95076	MM1	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing	XXX	1.50
●+95079	MM2	each additional 60 minutes of testing (List separately in addition to code for primary procedure) (Use 95079 in conjunction with 95076)	ZZZ	1.38

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95076 Tracking Number MM1 Original Specialty Recommended RVU: **2.11**
Presented Recommended RVU: **1.50**
Global Period: XXX RUC Recommended RVU: **1.50**

CPT Descriptor: Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year old with a history of an acute allergic reaction to peanut at age 2 years has been monitored by serial allergy skin and serum tests. She had no additional known exposures to peanut. The patient undergoes ingestion challenge testing to determine if her peanut allergy has resolved.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review vital signs obtained by clinical staff including baseline peak flow measurement. Review prior reaction history, skin test and lab results. Update history. Perform brief exam. The procedure, risks, and complications are reviewed and consent obtained.Verify that all required supplies and equipment are available, both for testing and for possible intervention if a reaction occurs. Written instructions are prepared for testing portions and dosing instructions.

Description of Intra-Service Work: Ingestion challenge testing of peanut butter is conducted. This typically involves incremental peanut butter dosing from a minute amount placed on the philtrum, followed by a minute amount placed on the tongue, followed by sequential ingestion of one-eighth, one-quarter, one-half, one, and two teaspoon(s) of peanut butter. Between the doses, there is a period of close patient monitoring for reaction (eg, hives, angioedema, wheezing) and assessing patient status prior to next dose. After the final dose, observation and monitoring are continued until the patient is considered clinically stable and a final physical examination is normal. The physician is available in the office for entire intra-service period [Note: Patient assessment/monitoring activities for allergic reaction (eg, blood pressure testing, peak flow meter testing) are not separately reported. Intervention therapy (eg, injection of steroid or epinephrine) may be reported separately as appropriate. For purposes of reporting testing times, if an evaluation and management service is required, then testing time ends.]

Description of Post-Service Work: Discuss possibility of delayed reaction. Confirm that the patient/family understands how to recognize a reaction and what to do if a reaction occurs. Final exam of patient before discharge from office. Dictate testing results and complete medical record documentation. Discuss results with referring physician and/or PCP (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Gary Gross, MD; Donald Aaronson, MD; Jacqueline Pongracic, MD		
Specialty(s):	allergy/immunology		
CPT Code:	95076		
Sample Size:	376	**Resp N:** 107	**Response:** 28.4 %
Description of Sample:	random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**24.00**	50.00	400.00
Survey RVW:	0.85	1.50	**2.11**	2.47	3.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**30.00**	50.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	95076	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92004	XXX	1.82	**RUC Time**	2,123,579

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.50	**RUC Time**	78,471,610

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 28.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 95076**	**Key Reference CPT Code:** 99215	**Source of Time** **RUC Time**
Median Pre-Service Time	7.00	5.00	
Median Intra-Service Time	30.00	35.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**42.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.61	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.03	3.82
Urgency of medical decision making	4.03	3.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.71	3.11
Physical effort required	3.03	3.04
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.61	3.43
Outcome depends on the skill and judgment of physician	4.29	3.71
Estimated risk of malpractice suit with poor outcome	4.71	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.52	3.13
Intra-Service intensity/complexity	4.23	3.87
Post-Service intensity/complexity	3.45	3.30

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

CPT code 95075 did not meet the utilization threshold for the CMS/RAW screen for "Different Performing Specialty from Survey." However, JCAAI determined that the work of code 95075 was based on the review by a specialty who is not the current dominant provider. In addition, JCAAI determined that the code approved for CPT 1993 is not consistent with work and variability of physician time in current practice. JCAAI applied to CPT for two new codes to describe ingestion challenge testing: one code for the initial 120 minutes of testing (typical, represents a negative test); and one add-on code to report additional increments of 60 minutes testing time to more accurately report the complete range of time and work involved in performing ingestion challenges.

Compelling Evidence

Change in Patient and Physician Work

Food allergies, the most common of the three types of allergens which are described by the current CPT code for an ingestion challenge (95075), affect more than 10 million Americans, including 3 million children. The prevalence of food allergies among children 18 years and younger increased 18% between 1997 and 2007. The most recent study of food allergy in this age cohort found a higher prevalence rate than had been reported previously. The rate of food allergies among children 18 years and younger was estimated at 8.0% (95% confidence interval [CI]: 7.6–8.3). The same study found that among children with food allergy, 38.7% had a history of severe reactions, and 30.4% had multiple food allergies. We do not have incidence data for allergies to other substances (drugs and metabilsulfite) but ingestion challenge for these items constitutes only about 10% of total ingestion challenges – the rest being for food.

The patient population and severity of food allergies is vastly different than it was in 1995 when code 95075 was reviewed by the RUC. The 1995 typical patient reacted to wheat with nasal congestion symptoms. As discussed above, over the last 15-20 years, there has been a significant increase in the number of individuals affected by food allergies and in the severity of symptoms. In the current population, we now see food allergies (most typically peanuts) that result in anaphylaxis and death (ie, not just nasal congestion). Although not typical in the office setting during testing, anaphylaxis and death is a serious concern, requiring close monitoring by the physician throughout the testing period. From 2003 to 2006, food allergies resulted in approximately 317,000 visits to hospital emergency departments, outpatient clinics and physicians' offices, using data from multiple US national surveys collected by the National Center for Health Statistics. The same study found that food allergy-related hospital admissions increased from 2,600 per year (1998-2000) to 9,500 per year (2004-2006). There are currently more than 125,000 ER visits related to food allergies in the US per year, of which some 12% are accompanied by an anaphylactic reaction. About 20% of these patients with a reaction may need to be hospitalized and, unfortunately, more than 100 may die.

In 2010, the National Institute of Allergy and Infectious Diseases, part of the National Institutes of Health, published "best practices" guidelines for the diagnosis and management of food allergy. In these guidelines, the time course of food-induced anaphylaxis is described as typically characterized by a defined exposure to a food allergen that is followed by a rapid onset and evolution of symptoms over minutes to several hours. Deaths from food-induced anaphylaxis have been reported within 30 minutes to 2 hours of exposure and usually result from cardiorespiratory compromise.

In 1995, the physician work was described by AAOHNS as intermittent assessment for one hour after ingestion of food containing wheat. If there was no reaction after one hour, 1/2 of the original portion was administered as a second does and the same observation occurs for the next hour. If there is no reaction after the second does, the test is considered negative. Intermittent assessment of the patient allergic to nuts is more complex than assessment of a patient allergic to wheat.

In current practice, the typical food ingestion challenge will be peanuts and the dosing will gradually increase (ie, a minute amount placed on the philtrum, followed by a minute amount placed on the tongue, followed by sequential ingestion of one-eighth, one-quarter, one-half, one, and two teaspoon(s) – or the equivalents in grams). These challenges will be administered every 15 to 20 minutes if no reaction is seen. Variation in patient-specific factors may impact testing intervals. For example, some tests require additional time and work because of the patient's ability to ingest a particular food allergen, typically because of fear caused by a prior experience, or age of the patient. This factor may necessitate how a food allergen is introduced and whether or not it needs to be masked and placebo-controlled or, presented in different forms for reasons of palatability or concomitant food allergies. This results in some patients

requiring more than the typical testing time for a negative reaction (95076). For all testing, the physician will need to be readily available nearby throughout the entire testing period as a reaction can occur quickly or be delayed. In practice, typically only one to two patients may be tested simultaneously since the possibility of a life threatening reaction can occur at any time and the physician needs to be available to intervene.

Change in Provider

In 1995, code 95075 was identified as potentially misvalued by the CMDs. Otolaryngology conducted a RUC survey. In 1994, otolaryngology provided this service, but was not the dominant provider. As seen in the table below, in current practice, allergy/immunology now comprises the significant majority of providers. Allergy/immunology did not participate in the 1995 review.

	1994	2010
Medicare utilization	**1,556**	**2,311**
allergy/immunology	41.30%	90.90%
otolaryngology	32.90%	0.65%
general/family practice	17.20%	0.48%
internal medicine	7.50%	3.72%

Flawed methodology for Previous Valuation

In 1995, AAOHNS recommended an increased work RVU for 95075, but the RUC determined that the specialty society only presented compelling evidence to maintain the current value of the code. The code was never surveyed by Harvard and not surveyed in 1992 after approval by CPT as a new code. The value approved in 1992 was based on the AAOHNS relative estimation of work RVUs, not a RUC survey.

Time and Work RVU Recommendations

Pre-time: We have chosen pre-time package 5 (non-facility procedure without sedation). This value is less than the survey median time, but representative of a minimum amount of time necessary to perform an review records and labs, review the procedure and risks with patient/family, obtain consent, confirm supply and equipment availability in the event of a reaction, and write orders for the testing procedure.

Intra-time: We recommend the survey median time of 30 minutes for physician brief exam and assessment of patient after each dose and before next dose (for 6 to 7 doses). This is equivalent to approximately 4 to 5 minutes per assessment and chart note.

Post-time: We recommend 5 minutes of post-service time to discuss the possibility of delayed reaction and confirm that the patient/family understands how to recognize a reaction and what to do if a reaction occurs. Perform a final brief exam of the patient before discharge from the office. Complete medical records and copy PCP (verbal and written).

Comparison of Key Reference Codes

Code 99215 was chosen by 31 respondents and code 99214 was chosen by 30 respondents.

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2006	99214	OV, estab patient (40 minutes face-to-face)	1.50	0.047	40	5	25	10
2012	***95076***	*Ingestion challenge, initial 120 min of testing*	***1.50***	***0.041***	***42***	***7***	***30***	***5***
2006	99215	OV, estab patient (40 minutes face-to-face)	2.11	0.047	55	5	35	15

As shown in the table below, 95076 includes more pre-service time and work than 99214, but less post-service work. We believe that total physician work for 95076 where the patient is in the physician's office for over 2 hours (pre+testing+post) is comparable to the total work for 99214. **Therefore, we recommend the survey 25th percentile work RVU of 1.50.**

CPT	DESCRIPTOR	RVW	PRE MIN	PRE WORK	INTRA MIN	POST MIN	POST WORK
95076	Ingestion challenge test; initial 120 minutes of testing	**1.50**	**7**	• Review vital signs obtained by clinical staff including baseline peak flow measurement. • Interval H&P performed including patient's medication history and pertinent medical problems that may have arisen since the previous visit • The procedure, risks, and	**30**	**5**	• Final exam of patient before discharge. • Discuss possibility of delayed reaction. Confirm that the patient/family understands how to recognize a reaction and what to do if a reaction occurs. • Dictate testing results and complete medical record

				complications are reviewed and consent obtained. • Verify that all required supplies and equipment are available, both for testing and for possible intervention if a reaction occurs. • Written instructions are prepared for testing portions.			documentation. Discuss results with referring physician and/or PCP (verbal and written).
99214	Office or other outpatient visit Physicians typically spend 25 minutes face-to-face with the patient and/or family.	**1.50**	**5**	• Review the medical history form completed by the patient and vital signs obtained by clinical staff	**25**	**10**	• Complete the medical record documentation • Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit • Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit • Receive and respond to any interval testing results or correspondence • Revise treatment plan(s) and communicate with patient, as necessary

MPC Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2007	**92004**	Eye exam new patient	1.82	0.059	40	5	25	10
2012	***95076***	*Ingestion challenge, initial 120 min of testing*	***1.50***	***0.041***	***42***	***7***	***30***	***5***
2006	99214	OV, estab patient (40 minutes face-to-face)	1.50	0.047	40	5	25	10

Other Code Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST
2012	***95076***	*Ingestion challenge, initial 120 min of testing*	***1.50***	***0.041***	***42***	***7***	***30***	***5***
2011	**99393**	Periodic preventive medicine reevaluation and management ; late childhood (age 5 through 11 years)	1.50	0.064	30	5	20	5

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95075

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty allergy/immunology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency is not known

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,311
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare data for 95075

Specialty allergy/immunology Frequency 2100 Percentage 90.86 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95180

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95079 Tracking Number MM2 Original Specialty Recommended RVU: **1.68**
Presented Recommended RVU: **1.38**
Global Period: ZZZ RUC Recommended RVU: **1.38**

CPT Descriptor: Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year old with a history of an acute allergic reaction to peanut at age 2 years has been monitored by serial allergy skin and serum tests. She had no additional known exposures to peanuts. While undergoing ingestion challenge testing to determine if her peanut allergy has resolved (first 120 minutes reported separately as 9507X1), she has a potential reaction requiring extended testing and additional testing is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The typical patient undergoing more than 120 minutes of ingestion challenge testing (reported separately with 9507X1) will have had one or more "potential" reactions during testing requiring additional/extended monitoring and assessment between doses. These reactions resolve, allowing testing to continue. Between the doses, there is a period of close patient monitoring for reaction (eg, hives, angioedema, wheezing) and assessing patient status prior to next dose. After the final dose, observation and monitoring are continued until the patient is considered clinically stable and a final physical examination is normal. The physician is available in the office for entire intra-service period. [Note: Patient assessment/monitoring activities for allergic reaction (eg, blood pressure testing, peak flow meter testing) are not separately reported. Intervention therapy (eg, injection of steroid or epinephrine) may be reported separately as appropriate. For purposes of reporting testing times, if an evaluation and management service is required, then testing time ends.]

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Gary Gross, MD; Donald Aaronson, MD; Jacqueline Pongracic, MD				
Specialty(s):	allergy/immunology				
CPT Code:	95079				
Sample Size:	376	**Resp N:**	104	**Response:** 27.6 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**10.00**	25.00	200.00
Survey RVW:	0.50	1.38	**1.68**	2.20	3.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**30.00**	40.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	95079	**Recommended Physician Work RVU: 1.38**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	17,085

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	17,093

CPT Descriptor 2 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95079**	**Key Reference CPT Code:** 99215	**Source of Time** RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	30.00	35.00	
Median Immediate Post-service Time	0.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.81	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.76
Urgency of medical decision making	4.46	3.68
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.85	3.16
Physical effort required	3.69	3.10
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.69	3.64
Outcome depends on the skill and judgment of physician	4.77	4.08
Estimated risk of malpractice suit with poor outcome	4.54	3.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.46	4.16
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

CPT code 95075 did not meet the utilization threshold for the CMS/RAW screen for "Different Performing Specialty from Survey." However, JCAAI determined that the work of code 95075 was based on the review by a specialty who is not the current dominant provider. In addition, JCAAI determined that the code approved for CPT 1993 is not consistent with work and variability of physician time in current practice. JCAAI applied to CPT for two new codes to describe ingestion challenge testing: one code for the initial 120 minutes of testing (typical, represents a negative test); and one add-on code to report additional increments of 60 minutes testing time to more accurately report the complete range of time and work involved in performing ingestion challenges.

Compelling Evidence

Change in Patient and Physician Work

Food allergies, the most common of the three types of allergens which are described by the current CPT code for an ingestion challenge (95075), affect more than 10 million Americans, including 3 million children. The prevalence of food allergies among children 18 years and younger increased 18% between 1997 and 2007. The most recent study of food allergy in this age cohort found a higher prevalence rate than had been reported previously. The rate of food allergies among children 18 years and younger was estimated at 8.0% (95% confidence interval [CI]: 7.6–8.3). The same study found that among children with food allergy, 38.7% had a history of severe reactions, and 30.4% had multiple food allergies. We do not have incidence data for allergies to other substances (drugs and metabilsulfite) but ingestion challenge for these items constitutes only about 10% of total ingestion challenges – the rest being for food.

The patient population and severity of food allergies is vastly different than it was in 1995 when code 95075 was reviewed by the RUC. The 1995 typical patient reacted to wheat with nasal congestion symptoms. As discussed above, over the last 15-20 years, there has been a significant increase in the number of individuals affected by food allergies and in the severity of symptoms. In the current population, we now see food allergies (most typically peanuts) that result in anaphylaxis and death (ie, not just nasal congestion). Although not typical in the office setting during testing, anaphylaxis and death is a serious concern, requiring close monitoring by the physician throughout the testing period. From 2003 to 2006, food allergies resulted in approximately 317,000 visits to hospital emergency departments, outpatient clinics and physicians' offices, using data from multiple US national surveys collected by the National Center for Health Statistics. The same study found that food allergy-related hospital admissions increased from 2,600 per year (1998-2000) to 9,500 per year (2004-2006). There are currently more than 125,000 ER visits related to food allergies in the US per year, of which some 12% are accompanied by an anaphylactic reaction. About 20% of these patients with a reaction may need to be hospitalized and, unfortunately, more than 100 may die.

In 2010, the National Institute of Allergy and Infectious Diseases, part of the National Institutes of Health, published "best practices" guidelines for the diagnosis and management of food allergy. In these guidelines, the time course of food-induced anaphylaxis is described as typically characterized by a defined exposure to a food allergen that is followed by a rapid onset and evolution of symptoms over minutes to several hours. Deaths from food-induced anaphylaxis have been reported within 30 minutes to 2 hours of exposure and usually result from cardiorespiratory compromise.

In 1995, the physician work was described by AAOHNS as intermittent assessment for one hour after ingestion of food containing wheat. If there was no reaction after one hour, 1/2 of the original portion was administered as a second does and the same observation occurs for the next hour. If there is no reaction after the second does, the test is considered negative. Intermittent assessment of the patient allergic to nuts is more complex than assessment of a patient allergic to wheat.

In current practice, the typical food ingestion challenge will be peanuts and the dosing will gradually increase (ie, a minute amount placed on the philtrum, followed by a minute amount placed on the tongue, followed by sequential ingestion of one-eighth, one-quarter, one-half, one, and two teaspoon(s) – or the equivalents in grams). These challenges will be administered every 15 to 20 minutes if no reaction is seen. Variation in patient-specific factors may impact testing intervals. For example, some tests require additional time and work because of the patient's ability to ingest a particular food allergen, typically because of fear caused by a prior experience, or age of the patient. This factor may necessitate how a food allergen is introduced and whether or not it needs to be masked and placebo-controlled or, presented in different forms for reasons of palatability or concomitant food allergies. This results in some patients requiring more than the typical testing time for a negative reaction (95076). For all testing, the physician will need to be readily available nearby throughout the entire testing period as a reaction can occur quickly or be delayed. In practice, typically only one to two patients may be tested simultaneously since the possibility of a life threatening reaction can occur at any time and the physician needs to be available to intervene.

Change in Provider

In 1995, code 95075 was identified as potentially misvalued by the CMDs. Otolaryngology conducted a RUC survey. In 1994, otolaryngology provided this service, but was not the dominant provider. As seen in the table below, in current practice, allergy/immunology now comprises the significant majority of providers. Allergy/immunology did not participate in the 1995 review.

	1994	2010
Medicare utilization	**1,556**	**2,311**
allergy/immunology	41.30%	90.90%
otolaryngology	32.90%	0.65%
general/family practice	17.20%	0.48%
internal medicine	7.50%	3.72%

Flawed methodology for Previous Valuation

In 1995, AAOHNS recommended an increased work RVU for 95075, but the RUC determined that the specialty society only presented compelling evidence to maintain the current value of the code. The code was never surveyed by Harvard and not surveyed in 1992 after approval by CPT as a new code. The value approved in 1992 was based on the AAOHNS relative estimation of work RVUs, not a RUC survey.

Work RVU Recommendation

Pre-time: No additional time.

Intra-time: The patient requiring additional monitoring will have had a potential reaction that will extend testing time. Physician work will increase. The intervals between testing will be extended with more frequent assessments during these intervals. The expert panel reviewing this work agrees with the survey median time of 30 minutes which is the same intra time for X1 and accounts for this additional work.

Post-time: No additional time.

Comparison of Key Reference Codes

Allergists do not perform services that have a ZZZ global period. The survey RSL included codes with a global period of XXX. This RSL was approved by the Research Subcommittee. Codes 99215 and 99214 were almost equally chosen by the survey respondents as a reference. We recommend the survey 25th percentile work RVU of 1.38. As the table below shows, this value takes into account the difference in work given the difference in global periods.

CPT	DESC	Glob	RVW	IWPUT	Tot Time	PRE	INTRA	POST
95079	*Ingestion challenge, add'l 60 min of testing*	***ZZZ***	***1.38***	***0.046***	***30***	***0***	***30***	***0***
99214	OV, estab patient (40 minutes face-to-face)	XXX	1.50	0.047	40	5	25	10
99215	OV, estab patient (40 minutes face-to-face)	XXX	2.11	0.047	55	5	35	15

MPC Comparison

The following two MPC codes with ZZZ global bracket the recommendation of X2. These are the lowest ZZZ global MPC.

CPT	DESC	Glob	RVW	IWPUT	Tot Time	PRE	INTRA	POST
13102	Repair, complex, trunk; each additional 5 cm or less	ZZZ	1.24	0.050	25	0	25	0
95079	*Ingestion challenge, add'l 60 min of testing*	***ZZZ***	***1.38***	***0.046***	***30***	***0***	***30***	***0***
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less	ZZZ	1.44	0.063	23	0	23	0

Other Code Comparison (all have ZZZ global)
The expert panel also looked at several other codes that have a ZZZ global and that support the recommendation of the survey 25th pctl work RVU of 1.38

Code 99359 requires 30 minutes of physician time related to additional review of records before and/or after a patient visit. This code does not include patient face-to-face assessment (which is reported as a separate EM service). Typically, pre and post-service work is valued at a lower intensity than the intra-service work. Therefore, the 30 minutes of 99359 would be at a lower intensity / value than 95079.

Code 99360 does not include patient face-to-face work. Typically, pre and post-service work is valued at a lower intensity than the intra-service work. Therefore, the 30 minutes of 99360 would be at a lower intensity / value than 95079.

Code 99355 is similar to new code 95079 in both code descriptor and description of work, however, the typical patient requiring 99355 is recovering from an office intervention and therefore represents a higher intensity of physician work compared with 95079 and therefore should have a higher value.

As discussed above and shown in the table below, the 25th percentile work RVU of 1.38 appropriately reflects the work of 95079.

RUC Year	CPT	DESC		RVW	IWPUT	Tot Time
2008	**99359**	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes	ZZZ	1.00	0.033	30
1993	**99360**	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	ZZZ	1.20	0.040	30
2012	***95079***	*Ingestion challenge, add'l 60 min of testing*	ZZZ	1.38	0.046	30
1993	**99355**	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	ZZZ	1.77	0.059	30

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95075-22, 99354, 99355

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty allergy/immunology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency is not known

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 233
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare data for 95075: 10% 95079 once plus 0.1% 95079 twice

Specialty allergy/immunology Frequency 233 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95180

SS Rec Summary

ISSUE: Ingestion Challenge Testing

TAB: 30 **REVISED 4-28-12**

							RVW					Total	pre	INTRA					post
SOURCE	CPT	DESC	Glob	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	P-SD
KEY REF	99215	OV, estab pt (40 min face-to-face)	XXX	31	0.047			2.11			55	5			35			15
MPC	99214	OV, estab pt (25 min face-to-face)	XXX		0.047			1.50			40	5			25			10
MPC	92004	Eye exam new patient	XXX		0.059			1.82			40	5			25			10
OTH	99393	Periodic preventive medicine reevaluation and management ; late childhood (age 5 through 11 years)	XXX		0.064			1.50			30	5			20			5
RUC '95	95075	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)	XXX		0.009			0.95			60	15			30			15
SVY	95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing	XXX	107	0.040	0.85	1.50	2.11	2.47	3.00	70	20	10	20	30	50	120	20
REC		25TH PERCENTILE			0.041		1.50				42	7			30			5

Time Discussion

Pre-time: We have chosen pre-time package 5 (non-facility procedure without sedation). This value is less than the survey median time, but representative of a minimum amount of time necessary to perform an review records and labs, review the procedure and risks with patient/family, obtain consent, confirm supply and equipment availability in the event of a reaction, and write orders for the testing procedure.

Intra-time: We recommend the survey median time of 30 minutes for physician brief exam and assessment of patient after each dose and before next dose (for 6 to 7 doses). This is equivalent to approximately 4 to 5 minutes per assessment and chart note.

Post-time: We recommend 5 minutes of post-service time to discuss the possibility of delayed reaction and confirm that the patient/family understands how to recognize a reaction and what to do if a reaction occurs. Perform a final brief exam of the patient before discharge from the office. Complete medical records and copy PCP (verbal and written).

REF	99215	OV, estab pt (40 min face-to-face)	XXX	26	0.047			2.11			55	5			35			15
MPC	13102	Repair, complex, trunk; each additional 5 cm	ZZZ		0.050			1.24			25				25			
MPC	13122	Repair, complex, scalp, arms, and/or legs; ea	ZZZ		0.063			1.44			23				23			
OTH	99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes	ZZZ		0.033			1.00			30				30			
OTH	99360	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	ZZZ		0.040			1.20			30				30			
OTH	99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	ZZZ		0.059			1.77			30				30			
CURRENT		N/A									0							
SVY	95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure)	ZZZ	104	0.056	0.50	1.38	1.68	2.20	3.00	30	0	10	20	30	40	60	0
REC		25TH PERCENTILE			0.046		1.38				30	0			30			0

Time Discussion

Pre-time: No additional time.

Intra-time: The patient requiring additional monitoring will have had a potential reaction that will extend testing time. Physician work will increase. The intervals between testing will be extended with more frequent assessments during these intervals. The expert panel reviewing this work agrees with the survey median time of 30 minutes which is the same intra time for X1 and accounts for this additional work.

Post-time: No additional time.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing
95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure)

Global Period XXX **Meeting Date**: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of allergists familiar with these new codes met by conference call to discuss direct practice expense details.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:
Code 95075 will be deleted for 2013 and replaced by new codes 95076 and 95079. The direct practice expense details of the to-be-deleted code was considered when the recommendations for the new codes were discussed by the expert panel. – No inputs recommended for facility.

Please describe in detail the clinical activities of your staff:
Pre-Service Clinical Labor Activities:
N/A

Service Clinical Labor Activities:

	95076	95079	
	XXX	ZZZ	
Greet patient, provide gowning, ensure appropriate medical records are available	3		**Std Time** - Test in NOT typically performed with E/M.
Obtain vital signs	3		**Std time for 1-3 vitals:** HR, RR, and BP.
Provide pre-service education/obtain consent	7		Typical patient is child. Discuss testing process with parent, including reaction signs to look for (clinical staff may not be face-to-face every minute of monitoring). Obtain consent.
Prepare testing doses	15		Weigh/measure prescribed testing doses, label / document.
Assist physician in performing procedure	7		Clinical staff time to administer 7+ oral challenge doses.
Monitor pt. following service/check tubes, monitors, drains	80	40	Clinical staff will monitor patient face-to-face at least 2/3 of the total testing time. (2/3 x 120 = 80) (2/3 x 60 = 40)
Clean room/equipment by physician staff	1		Although supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office.

Post-Service Clinical Labor Activities:
N/A

	A	B	C	D	E	F	G	H	I	J
1				**REFERENCE CODE** **PEAC 2005 - using OTO typical patient**						
2				**95075**		**95076**		**95079**		
3	**Meeting Date: April 2012** **Tab: 30** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)		initial 120 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance);		each additional 60 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other		**Notes**
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	
6	**TOTAL CLINICAL LABOR TIME**			**42**	**0**	**116**	**0**	**40**	**0**	
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**	**0**	**0**	
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**42**	**0**	**116**	**0**	**40**	**0**	
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**	**0**	**0**	
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
18	**End: When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
20	**Start: When patient enters office/facility for surgery/procedure:**									
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA			**3**				**Std Time** - Test in NOT typically performed with E/M.
22	Obtain vital signs	L037D	RN/LPN/MTA			**3**				**Std time for 1-3 vitals:** HR, RR, and BP.
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**7**		**7**				Typical patient is child. Discuss testing process with parent, including reaction signs to look for since clinical staff may not be face-to-face every minute of monitoring. Obtain consent.
24	Prepare room, equipment, supplies			**2**						
25	Prepare testing doses	L037D	RN/LPN/MTA			**15**				Weigh/measure prescribed testing doses, label / document.
26	Setup scope (non facility setting only)									
27	Prepare and position patient/ monitor patient/ set up IV									
28	Sedate/apply anesthesia									
29	**Intra-service**									
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**30**		**7**				Clinical staff time to administer 7+ oral challenge doses.
31	**Post-Service**									
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**80**		**40**		Clinical staff will monitor patient face-to-face at least 2/3 of the total testing time. (2/3 x 120 = 80) (2/3 x 60 = 40)
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			**1**				Although supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office.
34	Clean Scope									
35	Clean Surgical Instrument Package									
36	Complete diagnostic forms, lab & X-ray requisitions									
37	Review/read X-ray, lab, and pathology reports									
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions									
39	Other Clinical Activity - *specify:*									
40	**End: Patient leaves office**									
41	**POST-SERVICE Period**									
42	**Start: Patient leaves office/facility**									
55	**End: with last office visit before end of global period**									

	A	B	C	D	E	F	G	H	I	J
2				95075		95076		95079		
3	**Meeting Date: April 2012** **Tab: 30** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)		initial 120 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance)		each additional 60 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other		**Notes**
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**							
57	paper, exam table	SB036	foot	**7**		**7**				
58	gown, patient	SB026	item			**1**				Reactions can be dermal on the trunk and/or extremities requiring a gown for visual inspection
59	basin, emesis	SJ010	item			**1**				
60	cup, drinking	SK018	item	**1**		**1**				
61	spoon, plastic	SK077	item			**7**				
62	syringe 5-6ml	SC057	item			**1**				
63	**EQUIPMENT**	**CODE**								
64	table, exam	EF023		**42**		**141**		**60**		Total service-period minus prepartion of test doses
65	light, exam	EQ168				**141**		**60**		Total service-period minus prepartion of test doses
66	balance, scale	EP005				**15**		**0**		test dose prep time
67										
68										
69										
70					141 minutes = 120 min for the testing time plus other service period time minus preparation of test doses					

	A	B	C	D	E	F	G	H	I	J
1				**REFERENCE CODE** **PEAC 2005 - using OTO typical patient**						
2				**95075**		**95076**		**95079**		
3	**Meeting Date: April 2012** **Tab: 30** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)		initial 120 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance);		each additional 60 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other		**Notes**
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	
6	**TOTAL CLINICAL LABOR TIME**			**42**	**0**	**108**	**0**	**40**	**0**	
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**	**0**	**0**	
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**42**	**0**	**108**	**0**	**40**	**0**	
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**	**0**	**0**	
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
18	**End: When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
20	**Start: When patient enters office/facility for surgery/procedure:**									
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA			**3**				**Std Time** - Test in NOT typically performed with E/M.
22	Obtain vital signs	L037D	RN/LPN/MTA			**3**				**Std time for 1-3 vitals:** HR, RR, and BP.
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**7**		**7**				Typical patient is child. Discuss testing process with parent, including reaction signs to look for since clinical staff may not be face-to-face every minute of monitoring. Obtain consent.
24	Prepare room, equipment, supplies			**2**						
25	Prepare testing doses	L037D	RN/LPN/MTA			**7**				Weigh/measure prescribed testing doses, label / document.
26	Setup scope (non facility setting only)									
27	Prepare and position patient/ monitor patient/ set up IV									
28	Sedate/apply anesthesia									
29	**Intra-service**									
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**30**		**7**				Clinical staff time to administer 7+ oral challenge doses.
31	**Post-Service**									
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**80**		**40**		Clinical staff will monitor patient face-to-face at least 2/3 of the total testing time. (2/3 x 120 = 80) (2/3 x 60 = 40)
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			**1**				Although supplies will be disposed of while patient is being monitored, additional time to clean room is necessary for final cleaning after patient leaves office.
34	Clean Scope									
35	Clean Surgical Instrument Package									
36	Complete diagnostic forms, lab & X-ray requisitions									
37	Review/read X-ray, lab, and pathology reports									
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions									
39	Other Clinical Activity - *specify:*									
40	**End: Patient leaves office**									
41	**POST-SERVICE Period**									
42	**Start: Patient leaves office/facility**									
55	**End: with last office visit before end of global period**									

	A	B	C	D	E	F	G	H	I	J
2				95075		95076		95079		
3	**Meeting Date: April 2012** **Tab: 30** **Specialty: JCAAI**	**CMS Code**	**Staff Type**	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)		initial 120 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance)		each additional 60 minutes of testing - Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other		**Notes**
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**							
57	paper, exam table	SB036	foot	**7**		**7**				
58	gown, patient	SB026	item			**1**				Reactions can be dermal on the trunk and/or extremities requiring a gown for visual inspection
59	basin, emesis	SJ010	item			**1**				
60	cup, drinking	SK018	item	**1**		**1**				
61	spoon, plastic	SK077	item			**7**				
62	syringe 5-6ml	SC057	item			**1**				
63	**EQUIPMENT**	**CODE**								
64	table, exam	EF023		**42**		**133**		**60**		Total service-period minus prepartion of test doses
65	light, exam	EQ168				**133**		**60**		Total service-period minus prepartion of test doses
66	balance, scale	EP005				**7**		**0**		test dose prep time
67										
68										
69										
70					141 minutes = 120 min for the testing time plus other service period time minus preparation of test doses					

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Pediatric Polysomnography

In February 2012, the CPT Editorial Panel created 95782 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and 95783 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist* to describe the physician work involved in pediatric polysomnography for children 5 years of age or younger. These tests were previously reported using CPT codes 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and 95811 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist.* The RUC noted that although age distribution was not available for the original survey, the specialty society did survey their members and determined that the "under 6" age band indicated the point where physician work and intensity changed. The RUC survey vignettes for CPT codes 95810 and 95811 describe adult patients.

95782

The RUC reviewed the survey results from 89 physicians for 95782 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and determined that the physician work is accurately valued at the survey median work RVU of 3.00. The physician work involved is primarily in the interpretation of data which has become more intense due to a shift in patient population. The RUC noted that pediatric patients sleep longer (9 hours versus 8), are more prone to movement which causes leads to fall off and introduces artifacts and more likely to experience hypopnea which is more difficult to identify and review. The RUC compared 95782 to key reference service 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU=2.50) and determined that the surveyed code required more time and intensity, as discussed above, and should be valued higher. The RUC also reviewed CPT codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)(work RVU=2.78)* and agreed that with 15 minutes more time, 95782 should be valued higher. The RUC also reviewed 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended* (work RVU=3.08) and determined that the two services have identical intra-service time, 45 minutes, and are comparable in work. **The RUC recommends a work RVU of 3.00 for CPT Code 95782.**

95783

The RUC reviewed the survey results from 86 physicians for 95783 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist* and determined that physician work is accurately valued at the survey median work RVU of 3.20. The RUC noted that this sleep study is an hour

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longer than 95782 and includes a capnography and CPAP mask which increases the intensity of the procedure and interpretation of the data. Typically, there are 90-120 additional epochs to review in each pediatric polysomnogram. The RUC compared 95783 to key reference service 95811 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist* (work RVU=2.60) and determined that 95783 requires 20 more minutes to perform and is more intense, therefore, necessitating a higher value than the reference code. The RUC also reviewed 94012 *Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age (*work RVU=3.10) and agreed that although 94012 requires more time, the physician work of 95783 is more intense. In addition, a work RVU of 3.20 will maintain proper rank order for this family of services. **The RUC recommends a work RVU of 3.20 for CPT Code 95783.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Neurology and Neuromuscular Procedures** **Sleep Medicine Testing**				
Sleep medicine services include procedures that evaluate adult and pediatric patients for a variety of sleep disorders. Sleep medicine testing services are diagnostic procedures using in-laboratory and portable technology to assess physiologic data and therapy. All sleep services (95800-95811) include recording, interpretation and report. (Report with modifier 52 if less than 6 hours of recording for 95800, 95801 and 95806, 95807, 95810, 95811; if less than 7 hours of recording for 95782, 95783 or if less than four nap opportunities are recorded for 95805				
▲95808		Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	XXX	1.74 (No Change)

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▲95810		age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	XXX	2.50 (No Change)
▲95811		age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	XXX	2.60 (No Change)
#●95782	KK1	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	XXX	3.00
#●95783	KK2	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	XXX	3.20

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95782 Tracking Number KK1 Original Specialty Recommended RVU: **2.60**
Presented Recommended RVU: **3.00**
Global Period: XXX RUC Recommended RVU: **3.00**

CPT Descriptor: Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 5-year-old girl has enlarged tonsils and loud snoring. A polysomnogram is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Reviews study request from ordering qualified healthcare professional. Evaluates the clinical scenario for the test ordered. Determines appropriateness and duration of the test requested.

Description of Intra-Service Work: Reviews technologist summary and notes. Reviews the patient's sleep logs and comments on the pre, intra, and post sleep periods. Opens the sleep recording already downloaded to the reading station. Analyzes the raw data at 30 second intervals (epoch by epoch) for adequacy of recording signals and marked sleep stages. Analyzes the technologist's preliminary evaluation of artifacts, sleep stages and physiologic changes noted during the recording. Evaluates the recording for changes in respiration, EKG, oxygen saturation, EMG, periodic limb movements, sleep state and EEG and capnography. Correlates changes of all physiologic signals with the simultaneous video recording of the patient.
Decides if the total sleep time is adequate for interpretation. Determines if the recording addresses clinical question(s).

Description of Post-Service Work: Completes an interpretation of the data, establishes a diagnosis and creates the formal interpretive report. Communicates test results to the patient and the referring qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Amy Aronsky, DO, Burt Lesnick, MD, Steven Krug, MD, Marianna Spanaki, MD, PhD		
Specialty(s):	AAN, AAP, AASM, ACCP, ATS		
CPT Code:	95782		
Sample Size:	206	**Resp N:** 89	**Response:** 43.2 %
Description of Sample:	A survey was randomly sent to members.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	47.50	**150.00**	300.00	1200.00
Survey RVW:	1.50	2.60	**3.00**	3.50	4.18
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	30.00	**45.00**	60.00	150.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95782	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95810	XXX	2.50	**RUC Time**

CPT Descriptor Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
88189	XXX	2.23	**RUC Time**	164,952

CPT Descriptor 1 Flow cytometry, interpretation; 16 or more markers

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	84,807

CPT Descriptor 2 Broncoscopy, rigid or flexible, including fluroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
95811	XXX	2.60	**RUC Time**

CPT Descriptor Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 54 **% of respondents:** 60.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 95782**	**Key Reference CPT Code:** 95810	**Source of Time** **RUC Time**
Median Pre-Service Time	15.00	15.00	
Median Intra-Service Time	45.00	36.50	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**70.00**	**66.50**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.77
Urgency of medical decision making	3.60	3.47
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.43	4.00
Physical effort required	3.32	3.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	3.25
Outcome depends on the skill and judgment of physician	4.13	3.79
Estimated risk of malpractice suit with poor outcome	3.38	3.17

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	2.92
Intra-Service intensity/complexity	4.28	4.02
Post-Service intensity/complexity	3.36	3.26

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was previously reported as code 95810.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary Disease How often? Sometimes

Specialty Sleep Medicine How often? Sometimes

Specialty Neurology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on average of freqency data provided by two private insurance companies.

Specialty Pulmonary Disease Frequency 1140 Percentage 38.00 %

Specialty Sleep Medicine Frequency 720 Percentage 24.00 %

Specialty Neurology Frequency 480 Percentage 16.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This service is designed for pediatric patients ages under 6. Therefore it is estimated that this service will not be provided to Medicare patients

Specialty Pulmonary Disease Frequency 0 Percentage 0.00 %

Specialty Sleep Medicine Frequency 0 Percentage 0.00 %

Specialty Neurology Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95810

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95783 Tracking Number KK2 Original Specialty Recommended RVU: **2.83**
Presented Recommended RVU: **3.20**
Global Period: XXX RUC Recommended RVU: **3.20**

CPT Descriptor: Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old boy with obstructive sleep apnea presents with ongoing witnessed apneas and persistent daytime sleepiness after removal of tonsils and adenoids. A polysomnogram is ordered for continuous positive airway pressure titration.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Reviews sleep study request from ordering qualified healthcare professional. Evaluates the clinical scenario for the test ordered. Determines the appropriateness and duration of the test requested. Reviews pre-test consultation and data. Provides instruction on use of medications, including oxygen, by the patient during the day prior to the test and during the night of the test. Provides instruction to the night technologist hooking up the patient to the equipment, including starting pressures, sequences of pressures tested and the use of positive airway pressure devices.

Description of Intra-Service Work: Reviews technologist summary and notes. Opens the sleep recording already downloaded to the reading station. Analyzes the raw data at 30 second intervals (epoch by epoch) for adequacy of recording signals and marked sleep stages. Analyzes the technologist's preliminary evaluation of artifacts, sleep stages and physiologic changes noted during the recording. Evaluates the recording for changes in respiration, EKG, oxygen saturation, EMG, periodic limb movements, sleep state, EEG and capnography. Correlates changes of all physiologic signals with the simultaneous video recording of the patient. Evaluates the recording for optimal positive airway pressure application (mask). Decides if the total sleep time is adequate for interpretation. Analyzes the recording, including identification and assessment of abnormal events in the recording. Determines if the recording addresses clinical question(s).

Description of Post-Service Work: Completes an interpretation of the data, establishes a diagnosis and creates the formal interpretive report. Communicates test results to the patient and the referring qualfied healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Amy Aronsky, DO, Burt Lesnick, MD, Steven Krug, MD, Marianna Spanaki, MD, PhD		
Specialty(s):	AAN, AAP, AASM, ACCP, ATS		
CPT Code:	95783		
Sample Size:	206	**Resp N:** 86	**Response:** 41.7 %
Description of Sample:	A survey was randomly sent to members.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	50.00	400.00
Survey RVW:	1.50	2.83	**3.20**	3.75	10.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	31.25	**50.00**	60.00	180.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95783	**Recommended Physician Work RVU: 3.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**0.00**	**20.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95811	XXX	2.60	**RUC Time**

CPT Descriptor Polysomnography; sleep staging with 4 or more additional parameters ofsleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	2.50	**RUC Time**	311,700

CPT Descriptor 1 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.17	**RUC Time**	3,240,750

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient

Other Reference CPT Code	Global	Work RVU	Time Source
95953	000	3.08	**RUC Time**

CPT Descriptor Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 52 **% of respondents:** 60.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 95783**	**Key Reference CPT Code:** 95811	**Source of Time RUC Time**
Median Pre-Service Time	20.00	15.00	
Median Intra-Service Time	50.00	35.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**85.00**	**65.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	3.94
Urgency of medical decision making	3.92	3.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.49	3.92
Physical effort required	3.41	2.98
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.88	3.43
Outcome depends on the skill and judgment of physician	4.42	4.00
Estimated risk of malpractice suit with poor outcome	3.47	3.04

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.81	3.37
Intra-Service intensity/complexity	4.41	4.00
Post-Service intensity/complexity	3.91	3.44

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The societies met via teleconference and discussed the survey results. Representatives from the societies agreed that the 25th percentile RVU value was most appropriate for recommendation. They also agreed that the median survey times were accurate given the work involved in the service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was previously reported using code 95811.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary Disease How often? Rarely

Specialty Sleep Medicine How often? Rarely

Specialty Neurology How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 150
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on average of frequency data provided by two private insurance companies

Specialty Pulmonary Disease Frequency 60 Percentage 40.00 %

Specialty Sleep Medicine Frequency 36 Percentage 24.00 %

Specialty Neurology Frequency 24 Percentage 16.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This service is designed for pediatric patients ages under 6. Therefore it is estimated that this service will not be provided to Medicare patients

Specialty Pulmonary Disease Frequency 0 Percentage 0.00 %

Specialty Sleep Medicine Frequency 0 Percentage 0.00 %

Specialty Neurology Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95811

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Pediatric Polysomnography

TAB:

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	95810	Polysomnography; adult		0.050			2.50			66.5	15					37			15
CURRENT				#DIV/0!						0									
SVY	95782	Polysomnography: younger than 6 years	89	0.054	1.50	2.60	3.00	3.50	9.00	70	15			1	30	45	60	150	10
REC	95782	Polysomnography: younger than 6 years		0.054			3.00			70	15					45			10

ISSUE: Pediatric Polysomnography with PAP

TAB:

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	95811	Polysomnography; adult w/ PAP		0.055			2.60			65	15					35			15
CURRENT				#DIV/0!						0									
SVY	95783	Polysomnography; younger than 6 years w/ PAP	86	0.048	1.50	2.83	3.20	3.75	10.00	85	20			6	31	50	60	180	15
REC	95783	Polysomnography; younger than 6 years w/ PAP		0.048			3.20			85	20					50			15

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

95782

CPT Long Descriptor:
Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Global Period: XXX Meeting Date: April 25-29, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A Multispecialty Sleep Workgroup, including representatives from the American Academy of Pediatrics, American Academy of Sleep Medicine, American College of Chest Physicians and American Thoracic Society met to discuss recommendations for practice expense. Pediatric sleep experts from the societies were included in the workgroup. The workgroup came to consensus on the recommendations over phone and email discussions.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

The reference code used for practice expense inputs was 95810. This code was selected because it describes the same procedure as code 95782 except it is performed on an adult and not a pediatric patient. Equipment and supplies for these codes are very similar and the logic used to calculate time for both procedures is similar.

Please describe in detail the clinical activities of your staff:

Pre-service Clinical Labor Activities:
- Complete pre-service diagnostic and referral forms
- Coordinate pre-service testing

Service Clinical Labor Activities:
- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/obtain consent, including familiarizing both parent and child with the room and equipment
- Prepare room, equipment supplies
- Set up and calibrate all monitoring and recording equipment
- Measure and mark head and face. Apply and secure electrodes to head and face. Check impedances. (1.5 minutes per electrode)
- Apply recording devices for cardio-respiratory, leg movements, body positioning, snoring and capnography
- Perform procedure (9 hours recording time and 1 night technician for every 1 patient)
- Reapply electrodes as needed (typically at least 2 per night).
- Remove and clean electrodes and recording devices
- Clean room, change the sheets and prepare room for next day

Post-Service Clinical Labor Activities:

- Daytime technician reviews and edits recording, marks artifacts, scores sleep stages, performs evaluation of physiological changes
- Prepare technician report
- Transfer record to reading station and archive data

95783

CPT Long Descriptor:
Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Global Period: XXX Meeting Date: April 25-29, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A Multispecialty Sleep Workgroup, including representatives from the American Academy of Pediatrics, American Academy of Sleep Medicine, American College of Chest Physicians and American Thoracic Society met to discuss recommendations for practice expense. Pediatric sleep experts from the societies were included in the workgroup. The workgroup came to consensus on the recommendations over phone and email discussions.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

The reference code used for practice expense inputs was 95811. This code was selected because it describes the same procedure as code 95783 except it is performed on an adult and not a pediatric patient. Equipment and supplies for these codes are very similar and the logic used to calculate time for both procedures is similar.

Please describe in detail the clinical activities of your staff:
Pre-service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-service testing

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/obtain consent, including familiarizing both parent and child with the room and equipment
- Prepare room, equipment supplies
- Set up and calibrate all monitoring and recording equipment
- Measure and mark head and face. Apply and secure electrodes to head and face. Check impedances. (1.5 minutes per electrode)
- Apply recording devices for cardio-respiratory, leg movements, body positioning, snoring and capnography
- Reapply electrodes as needed (typically at least 2 per night)
- CPAP titration including selection and fitting of masks, working with child to accommodate them to mask
- Perform procedure (9 hours recording time and 1 night technician for every 1 patient)

- Remove and clean electrodes and recording devices
- Clean room, change the sheets and prepare room for next day

Post-Service Clinical Labor Activities:

- Daytime technician reviews and edits recording, marks artifacts, scores sleep stages, performs evaluation of physiological changes
- Develop spreadsheet indicating how sleep parameters varied with different levels of positive pressure
- Prepare technician report
- Transfer record to reading station and archive data

Tab 31 Pediatric Polysomnography Practice Expense
Justification for Differences Between Adult (95810 and 95811) and Pediatric Codes (95782 and 95783)

TIME

Difference	Justification
1 minute increase in calibration of monitoring equipment	Calibration of capnograph is not required for adult services. This calibration takes 1 minute.
10 minutes additional time for electrode application	Application of each electrode typically takes 60 seconds for an adult and 90 seconds for a pediatric patient. This difference in time was documented by members of our practice expense workgroup.
5 minutes additional time for applying recording devices	Application of the capnograph is required for pediatric services (not for adult). Additionally, the equipment is typically more difficult to apply on a pediatric patient. This difference in time was documented by members of our practice expense workgroup.
10 minutes additional time for CPAP titration selection of masks, etc	Desensitizing a pediatric patient to CPAP mask is more difficult than with an adult.
300 additional minutes in recording time	Pediatric patients require an additional hour of recording time. Additionally, a technologist to patient ratio of 1:1 is typically required for pediatric patients, as confirmed by a survey of sleep physicians treating pediatric patients under age 6. This ratio is being considered as an accreditation requirement for AASM sleep facilities.
14 additional minutes tech scoring	An additional 12.5% of recording time is required for pediatric studies, which amounts to 11 additional minutes of scoring time. Additionally, the added capnography channel accounts for an additional 3 minutes of scoring time.

SUPPLIES/EQUIPMENT

Difference	Justification
• 2 additional gauze items • 4 additional electrode skin prep tape items • 2 additional alcohol swab-pads	Typically 2 electrodes fall off or are pulled off during the night while a pediatric patient is tested. Additional gauze (1 per electrode) is required for reapplication.
Self-adherent wrap	A wrap is required for pediatric patients to help keep electrodes on.
Pediatric airflow and CO2 cannula	A combination cannula is used to measure CO2 (with the capnograph) and airflow in pediatric patients
60 additional minutes are	The pediatric patient is monitored for an additional 60

required for almost all equipment (except diagnostic system)	minutes.
Capnograph	Capnography is required for pediatric polysomnography.
Crib	Patients in this age range (below age 6) typically sleep in a crib while the parent occupies the bed.
Low light camera with zoom	The camera used to value adult studies in 2010 is no longer an active item on the equipment list. Sleep studies require a low light camera with a zoom feature to record the study.

	A	B	C	D	E	F	G
1				Ref Code		Ref Code	
2				95810	95782	95811	95783
3	**Meeting Date: April 26-29, 2012** **Tab:** **Specialty: AAN, AAP, AASM, ACCP/ATS**	**CMS Code**	**Staff Type**	Polysomnography, ages 6 and older, 4 or more	Polysomnography, younger than 6 years, 4 or more	Polysomnography, ages 6 and older, w/cpap	Polysomnography, younger than 6 years, w/cpap
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**411.0**	**743.0**	**446.0**	**798.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**6.0**	**6.0**	**6.0**	**6.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**317.0**	**635.0**	**352.0**	**680.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**88.0**	**102.0**	**88.0**	**112.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L047B	REEGT	**3**	**3**	**3**	**3**
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity - *specify:* Coordinate pre-service testing	L047B	REEGT	**3**	**3**	**3**	**3**
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available	L047B	REEGT	**3**	**3**	**3**	**3**
22	Obtain vital signs	L047B	REEGT	**5**	**5**	**5**	**5**
23	Provide pre-service education/obtain consent, (familiarize both parent and child to room and equipment for pediatric study)	L047B	REEGT	**3**	**5**	**3**	**5**
24	Prepare room, equipment, supplies	L047B	REEGT	**5**	**5**	**5**	**5**
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	Other Clinical Activity - *specify:* Set up and calibrate all monitoring and recording equipment (initial), including capnograph (for child)	L047B	REEGT	**5**	**6**	**5**	**6**
29	**Intra-service**						
30	Assist physician in performing procedure						
31	Other Clinical Activity - *specify:* Measure and mark head and face. Apply and secure electrodes to head and face. Check impedances. Reapply electrodes as needed. (1.5 min per electrode for child, 1 min per electrode for adult)	L047B	REEGT	**20**	**30**	**20**	**30**
32	Other Clinical Activity - *specify:* Apply recording devices for cardio-respiratory, leg movements, body positioning and snoring	L047B	REEGT	**15**		**15**	
33	Other Clinical Activity - specify: Apply recording devices for cardio-respiratory, leg movements, body positioning, snoring and capnography	L047B	REEGT		**20**		**20**
34	Other Clinical Activity - *specify:* CPAP titration including selection and fitting of masks (assist child in accomodating to mask)	L047B	REEGT			**35**	**45**
35	Other Clinical Activity - *specify:* Performs procedure (8 hours recording time and 1 night technician for every 2 patients)	L047B	REEGT	**240**		**240**	

	A	B	C	D	E	F	G
1				Ref Code		Ref Code	
2				95810	95782	95811	95783
3	**Meeting Date: April 26-29, 2012** **Tab:** **Specialty: AAN, AAP, AASM, ACCP/ATS**	**CMS Code**	**Staff Type**	Polysomnography, ages 6 and older, 4 or more	Polysomnography, younger than 6 years, 4 or more	Polysomnography, ages 6 and older, w/cpap	Polysomnography, younger than 6 years, w/cpap
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
36	Other Clinical Activity - *specify:* Performs procedure (9 hours recording time and 1 night technician for every 1 patient)	L047B	REEGT		**540**		**540**
37	**Post-Service**						
38	Monitor pt. following service/check tubes, monitors, drains						
39	Clean room/equipment by physician staff						
40	Clean Scope						
41	Clean Surgical Instrument Package						
42	Complete diagnostic forms, lab & X-ray requisitions						
43	Review/read X-ray, lab, and pathology reports						
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
45	Other Clinical Activity - *specify:* Remove and clean electrodes and recording devices	L047B	REEGT	**18**	**18**	**18**	**18**
46	Other Clinical Activity - *specify:* Clean room, change the sheets and prepare room for next day	L047B	REEGT	**3**	**3**	**3**	**3**
47	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	**n/a**	**n/a**	**n/a**
48	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**	**n/a**	**n/a**	**n/a**
49	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**	**n/a**	**n/a**	**n/a**
50	**End: Patient leaves office**						
51	**POST-SERVICE Period**						
52	**Start: Patient leaves office/facility**						
53	Conduct phone calls/call in prescriptions						
54	Other Clinical Activity - *specify:* Daytime tech reviews and edits recording, marks artifacts, scores sleep stages, performs evaluation of physiological changes	L047B	REEGT	**86**	**100**	**86**	**100**
55	Other Clinical Activity - *specify:* Technician prepares spreadsheet indicating how sleep parameters varied with different levels of positive pressure	L047B	REEGT				**10**
56	Other Clinical Activity - *specify:* Prepare technican report (day technician)	L047B	REEGT	**2**	**2**	**2**	**2**
57	Other Clinical Activity - *specify:* Transfer record to reading station and archie data	L047B	REEGT	**0**	**0**	**0**	**0**
58	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
59	99211 16 minutes		16				
60	99212 27 minutes		27				
61	99213 36 minutes		36				
62	99214 53 minutes		53				
63	99215 63 minutes		63				
64	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
65	Other Clinical Activity - *specify:*						
66	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				Ref Code		Ref Code	
2				95810	95782	95811	95783
3	**Meeting Date: April 26-29, 2012** **Tab:** **Specialty: AAN, AAP, AASM, ACCP/ATS**	**CMS Code**	**Staff Type**	Polysomnography, ages 6 and older, 4 or more	Polysomnography, younger than 6 years, 4 or more	Polysomnography, ages 6 and older, w/cpap	Polysomnography, younger than 6 years, w/cpap
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
67	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
68	pack, minimum multi-specialty visit	SA048	pack				
69	sanitizing cloth-wipe (surface, instruments, equipment) (head box and electrical wires)	SM022	item	**1**	**1**	**1**	**1**
70	paper, laser printing (each sheet)	SK057	item	**4**	**4**	**4**	**4**
71	computer media, dvd	SK013	item	**1**	**1**	**1**	**1**
72	gloves, non-sterile	SB022	pair	**4**	**4**	**4**	**4**
73	needle, blunt tip (for EEG/EMG electrodes)	SC034	item	**1**	**1**	**1**	**1**
74	syringe 10-12ml (for EEG/EMG electrodes)	SC051	item	**1**	**1**	**1**	**1**
75	electrode, ECG (single)	SD053	item	**2**	**2**	**2**	**2**
76	applicator, cotton tipped, non-sterile 6in	SG008	item	**2**	**2**	**2**	**2**
77	gauze, non-sterile 2in x 2 in (per 2 electrodes)	SG050	item	**9**	**11**	**9**	**11**
78	electrode, conductive paste (Ten20)	SJ021	oz	**4**	**4**	**4**	**4**
79	EEG and EMG, 2 inches per electrode skin prep tape (One Step)	SJ023	inch	**36**	**40**	**36**	**40**
80	swab-pad, alcohol (per electrode)	SJ053	item	**18**	**20**	**18**	**20**
81	oximetry sensor wrap	SD104	item	**1**	**1**	**1**	**1**
82	sensor, airflow cannula (adult)	SD112	item	**1**		**1**	
83	measuring tape, paper	SK048	item	**1**	**1**	**1**	**1**
84	skin marking pen, sterile (Skin Skribe)	SK075	item	**1**	**1**	**1**	**1**
85	sanitizing cloth-wipe (patient) (to remove glue)	SM021	item	**2**	**2**	**2**	**2**
86	sensor, airflow and CO2 cannula (pediatric)*		item		**1**		**1**
87	self-adherent wrap*		item		**1**		**1**
88							
89	**EQUIPMENT**	**CODE**					
90	camera, remote-autoswitching	ED007	minutes	**600**	note - this item is no longer active	**600**	note - this item is no longer active
91	Bedroom furniture (hospital bed, table, reclining chair)	EF003	minutes	**600**	**660**	**600**	**660**
92	impedance meter, 32 channel	EQ134	minutes	**600**	**660**	**600**	**660**
93	infrared illuminator		minutes	**600**	**660**	**600**	**660**
94	Sleep diagnostic system, attended (w-acquisition station, review master, computer)	EQ272	minutes	**720**	**720**	**720**	**720**
95	sleep screening system, attended (w/resp. plethysmography)	EQ228	minutes	**600**	**660**	**600**	**660**
96	CPAP/BiPAP remote clinical unit	EQ005	minutes			**600**	**660**
97	Respiratory impedance Plethysmography Belts (pair)*		minutes	**600**	**660**	**600**	**660**
98	capnograph*		minutes		**660**		**660**
99	crib*		minutes		**660**		**660**
100	low light camera with zoom*		minutes		**660**		**660**
101							
102	*Denotes item for which receipt will be provided						

	A	B	C	D	E	F	G
1				Ref Code		Ref Code	
2				95810	95782	95811	95783
3	**Meeting Date: April 26-29, 2012** **Tab:** **Specialty: AAN, AAP, AASM, ACCP/ATS**	**CMS Code**	**Staff Type**	Polysomnography, ages 6 and older, 4 or more	Polysomnography, younger than 6 years, 4 or more	Polysomnography, ages 6 and older, w/cpap	Polysomnography, younger than 6 years, w/cpap
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**411.0**	**727.0**	**446.0**	**782.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**6.0**	**9.0**	**6.0**	**9.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**317.0**	**619.0**	**352.0**	**664.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**88.0**	**99.0**	**88.0**	**109.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L047B	REEGT	**3**	**3**	**3**	**3**
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent				**3**		**3**
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity - *specify:* Coordinate pre-service testing	L047B	REEGT	**3**	**3**	**3**	**3**
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available	L047B	REEGT	**3**	**3**	**3**	**3**
22	Obtain vital signs	L047B	REEGT	**5**	**5**	**5**	**5**
23	Provide pre-service education/obtain consent, (familiarize both parent and child to room and equipment for pediatric study)	L047B	REEGT	**3**	**5**	**3**	**5**
24	Prepare room, equipment, supplies	L047B	REEGT	**5**	**5**	**5**	**5**
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	Other Clinical Activity - *specify:* Set up and calibrate all monitoring and recording equipment (initial), including capnograph (for child)	L047B	REEGT	**5**	**5**	**5**	**5**
29	**Intra-service**						
30	Assist physician in performing procedure						
31	Other Clinical Activity - *specify:* Measure and mark head and face. Apply and secure electrodes to head and face. Check impedances. Reapply electrodes as needed. (1.5 min per electrode for child, 1 min per electrode for adult)	L047B	REEGT	**20**	**20**	**20**	**20**
32	Other Clinical Activity - *specify:* Apply recording devices for cardio-respiratory, leg movements, body positioning and snoring	L047B	REEGT	**15**	**15**	**15**	**15**
33	Other Clinical Activity - specify: Apply recording devices for cardio-respiratory, leg movements, body positioning, snoring and capnography	L047B	REEGT		**0**		**0**
34	Other Clinical Activity - *specify:* CPAP titration including selection and fitting of masks (assist child in accomodating to mask)	L047B	REEGT			**35**	**45**
35	Other Clinical Activity - *specify:* Performs procedure (8 hours recording time and 1 night technician for every 2 patients)	L047B	REEGT	**240**		**240**	

	A	B	C	D	E	F	G
1				Ref Code		Ref Code	
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3	**Meeting Date: April 26-29, 2012** **Tab:** **Specialty: AAN, AAP, AASM, ACCP/ATS**	**CMS Code**	**Staff Type**	Polysomnography, ages 6 and older, 4 or more	Polysomnography, younger than 6 years, 4 or more	Polysomnography, ages 6 and older, w/cpap	Polysomnography, younger than 6 years, w/cpap
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
36	Other Clinical Activity - *specify:* Performs procedure (9 hours recording time and 1 night technician for every 1 patient)	L047B	REEGT		**540**		**540**
37	**Post-Service**						
38	Monitor pt. following service/check tubes, monitors, drains						
39	Clean room/equipment by physician staff						
40	Clean Scope						
41	Clean Surgical Instrument Package						
42	Complete diagnostic forms, lab & X-ray requisitions						
43	Review/read X-ray, lab, and pathology reports						
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
45	Other Clinical Activity - *specify:* Remove and clean electrodes and recording devices	L047B	REEGT	**18**	**18**	**18**	**18**
46	Other Clinical Activity - *specify:* Clean room, change the sheets and prepare room for next day	L047B	REEGT	**3**	**3**	**3**	**3**
47	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	**n/a**	**n/a**	**n/a**
48	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**	**n/a**	**n/a**	**n/a**
49	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**	**n/a**	**n/a**	**n/a**
50	**End: Patient leaves office**						
51	**POST-SERVICE Period**						
52	**Start: Patient leaves office/facility**						
53	Conduct phone calls/call in prescriptions						
54	Other Clinical Activity - *specify:* Daytime tech reviews and edits recording, marks artifacts, scores sleep stages, performs evaluation of physiological changes	L047B	REEGT	**86**	**97**	**86**	**97**
55	Other Clinical Activity - *specify:* Technician prepares spreadsheet indicating how sleep parameters varied with different levels of positive pressure	L047B	REEGT				**10**
56	Other Clinical Activity - *specify:* Prepare technican report (day technician)	L047B	REEGT	**2**	**2**	**2**	**2**
57	Other Clinical Activity - *specify:* Transfer record to reading station and archie data	L047B	REEGT	**0**	**0**	**0**	**0**
58	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
59	99211 16 minutes		16				
60	99212 27 minutes		27				
61	99213 36 minutes		36				
62	99214 53 minutes		53				
63	99215 63 minutes		63				
64	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
65	Other Clinical Activity - *specify:*						
66	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				Ref Code		Ref Code	
2				95810	95782	95811	95783
3	**Meeting Date: April 26-29, 2012** **Tab:** **Specialty: AAN, AAP, AASM, ACCP/ATS**	**CMS Code**	**Staff Type**	Polysomnography, ages 6 and older, 4 or more	Polysomnography, younger than 6 years, 4 or more	Polysomnography, ages 6 and older, w/cpap	Polysomnography, younger than 6 years, w/cpap
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
67	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
68	pack, minimum multi-specialty visit	SA048	pack				
69	sanitizing cloth-wipe (surface, instruments, equipment) (head box and electrical wires)	SM022	item	**1**	**1**	**1**	**1**
70	paper, laser printing (each sheet)	SK057	item	**4**	**4**	**4**	**4**
71	computer media, dvd	SK013	item	**1**	**1**	**1**	**1**
72	gloves, non-sterile	SB022	pair	**4**	**4**	**4**	**4**
73	needle, blunt tip (for EEG/EMG electrodes)	SC034	item	**1**	**1**	**1**	**1**
74	syringe 10-12ml (for EEG/EMG electrodes)	SC051	item	**1**	**1**	**1**	**1**
75	electrode, ECG (single)	SD053	item	**2**	**2**	**2**	**2**
76	applicator, cotton tipped, non-sterile 6in	SG008	item	**2**	**2**	**2**	**2**
77	gauze, non-sterile 2in x 2 in (per 2 electrodes)	SG050	item	**9**	**11**	**9**	**11**
78	electrode, conductive paste (Ten20)	SJ021	oz	**4**	**4**	**4**	**4**
79	EEG and EMG, 2 inches per electrode skin prep tape (One Step)	SJ023	inch	**36**	**40**	**36**	**40**
80	swab-pad, alcohol (per electrode)	SJ053	item	**18**	**20**	**18**	**20**
81	oximetry sensor wrap	SD104	item	**1**	**1**	**1**	**1**
82	sensor, airflow cannula (adult)	SD112	item	**1**		**1**	
83	measuring tape, paper	SK048	item	**1**	**1**	**1**	**1**
84	skin marking pen, sterile (Skin Skribe)	SK075	item	**1**	**1**	**1**	**1**
85	sanitizing cloth-wipe (patient) (to remove glue)	SM021	item	**2**	**2**	**2**	**2**
86	sensor, airflow and CO2 cannula (pediatric)*		item		**1**		**1**
87	self-adherent wrap*		item		**1**		**1**
88							
89	**EQUIPMENT**	**CODE**					
90	camera, remote-autoswitching	ED007	minutes	**600**	note - this item is no longer active	**600**	note - this item is no longer active
91	Bedroom furniture (hospital bed, table, reclining chair)	EF003	minutes	**600**	**602**	**600**	**647**
92	impedance meter, 32 channel	EQ134	minutes	**600**	**602**	**600**	**647**
93	infrared illuminator		minutes	**600**	**602**	**600**	**647**
94	Sleep diagnostic system, attended (w-acquisition station, review master, computer)	EQ272	minutes	**720**	**662**	**720**	**707**
95	sleep screening system, attended (w/resp. plethysmography)	EQ228	minutes	**600**	**660**	**600**	**660**
96	CPAP/BiPAP remote clinical unit	EQ005	minutes			**600**	**660**
97	Respiratory impedance Plethysmography Belts (pair)*		minutes	**600**	**660**	**600**	**660**
98	capnograph*		minutes		**0**		**0**
99	crib*		minutes		**0**		**0**
100	low light camera with zoom*		minutes		**660**		**660**
101							
102	*Denotes item for which receipt will be provided						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More screen

April 2012

EMG in Conjunction with Nerve Testing

In February 2010, CPT codes 95860, 95861, 95863 and 95864 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are billed commonly with 95904. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created three new ZZZ global codes to be reviewed at the RUC in April 2011. The CPT Editorial Panel noted, and the RUC agreed, that these three new codes were approved with the intent that the specialties will take additional time and bring forward a more comprehensive coding solution which bundles services commonly performed together during the CPT 2013 cycle. In February 2012, the CPT Editorial Panel created seven new codes that bundle the work of multiple nerve conduction studies into each individual code.

95860 ***Needle electromyography; 1 extremity with or without related paraspinal areas***
The RUC reviewed the survey results from 93 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 20 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.96 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) and agreed that while 95860 has greater intra-service time compared to the reference code, 20 minutes and 15 minutes, respectively, the two services have analogous physician work and should be valued similarly. **The RUC recommends a work RVU of 0.96 for CPT code 95860.**

95861 ***Needle electromyography; 2 extremities with or without related paraspinal areas***
The RUC reviewed the survey results from 46 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 29 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the current work RVU of 1.54, slightly above the survey 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC reviewed the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that 95861 should be valued slightly higher than the reference code due to slightly greater intra-service time, 29 minutes and 25 minutes, respectively. **The RUC recommends a work RVU of 1.54 for CPT code 95861.**

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95863 ***Needle electromyography; 3 extremities with or without related paraspinal areas***
The RUC reviewed the survey results from 46 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 40 minutes and post-service time= 11 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.87 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 2.11) and agreed that 95863 has analogous total physician time compared to the reference code, 61 minutes and 55 minutes, respectively, and should be valued slightly less. **The RUC recommends a work RVU of 1.87 for CPT code 95863.**

95864 ***Needle electromyography; 4 extremities with or without related paraspinal areas***
The RUC reviewed the survey results from 46 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 50 minutes and post-service time= 13.5 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.99 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50) and agreed that while 95864 should be valued less because it is a less involved, complex service. **The RUC recommends a work RVU of 1.99 for CPT code 95864.**

95865 ***Needle electromyography; larynx***
The RUC reviewed the survey results from practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 6.5 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the current value of 1.57 work RVUs accurately reflects the physician work involved in the service. To justify this value, the RUC reviewed the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that 95865 should be valued slightly higher because that it is a much more intense service compared to the reference code, as shown by the survey respondents' intensity/complexity measures. In addition, the RUC reviewed CPT code 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)* (work RVU= 1.62) and agreed that since the two services have identical intra-service times, 15 minutes, and comparable physician work, the work values should be similar. **The RUC recommends a work RVU of 1.57 for CPT code 95865.**

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95866 ***Needle electromyography; hemidiaphragm***
The RUC reviewed the survey results from practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.25 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that the reference code should be valued slightly higher than 95866 due to greater total time, 40 minutes compared to 35 minutes. **The RUC recommends a work RVU of 1.25 for CPT code 95866.**

95867 ***Needle electromyography; cranial nerve supplied muscle(s), unilateral***
The RUC reviewed the survey results from 39 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.79 work RVUs, for this service. To justify this value, the RUC reviewed CPT code 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up, transabdominal approach, per fetus* (work RVU= 0.85) and agreed that the two services should be valued similarly because they have identical intra-service times of 15 minutes and analogous total time. Additionally, the RUC compared 95867 to 95866 and noted that while both services have the same physician times, the survey respondents rated 95866 as a more intense and complex service compared to 95867. **The RUC recommends a work RVU of 0.79 for CPT code 95867.**

95868 ***Needle electromyography; cranial nerve supplied muscles, bilateral***
The RUC reviewed the survey results from 40 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 20 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.18 work RVUs, for this service. To justify this value, the RUC reviewed key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that reference code should be valued higher because of greater intra-service time compared to 95868, 25 minutes and 20 minutes, respectively. **The RUC recommends a work RVU of 1.18 for CPT code 95868.**

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95869 ***Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)***
The RUC reviewed the survey results from 43 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.37 work RVUs, for this service. To justify this value, the RUC reviewed CPT code 94452 *High altitude simulation test (HAST), with physician interpretation and report* (work RVU= 0.31) and agreed that the two services have comparable physician work, but 95869 should be valued higher due to greater total time compared to the reference code, 35 minutes and 30 minutes, respectively. **The RUC recommends a work RVU of 0.37 for CPT code 95869.**

95870 ***Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters***
The RUC reviewed the survey results from 43 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.37 work RVUs, for this service. To justify this value, the RUC reviewed CPT code 94452 *High altitude simulation test (HAST), with physician interpretation and report* (work RVU= 0.31) and agreed that the two services have comparable physician work, but 95869 should be valued higher due to greater total time compared to the reference code, 35 minutes and 30 minutes, respectively. The RUC also compared 95870 to 95869 and agreed that with identical physician time components the two services should be valued identically. **The RUC recommends a work RVU of 0.37 for CPT code 95870.**

95907 ***1-2 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the respondents' estimated physician work values and agreed with the specialty that the median work RVU of 1.00 accurately reflects the physician work of this bundled code. To justify this value, the RUC compared the surveyed code to CPT code 93890 *Transcranial Doppler study of the intracranial arteries; vasoreactivity study* (work RVU= 1.00) and agreed that the two services have comparable physician work, with identical time components, and should be valued identically. The RUC also reviewed CPT code 94004 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day* (work RVU= 1.00) and agreed that 95907 should have the same work value to ensure relativity to this reference code because they have identical time. **The RUC recommends a work RVU of 1.00 for CPT code 95907.**

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95908 ***3-4 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the intra-service time for this code did not fit in proper relativity within the family. To determine more accurate intra-service time, the Committee noted that nerve conduction studies are typically done in pairs, thus using the approved physician time from the base code 95907, 15 minutes, the RUC agreed that 7.5 minutes per nerve was a reasonable increment to assess the physician work of 95908. The RUC then conservatively assumed an increase of 1.5 nerves per bundled code, resulting in an additional 10 minutes, from the base code, of intra-service time for 95908. The recommended physician time components are: pre-service time= 10 minutes, intra-service time= 25 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC also noted that the survey's estimated work value was overestimated at the median level, 1.68 work RVUs. To determine an appropriate value, the RUC compared the physician work of 95908 to CPT code 62270 *Spinal puncture, lumbar, diagnostic* (work RVU= 1.37) and agreed that the two services have comparable physician work and physician total time, 40 minutes and 45 minutes, respectively. Given this close comparison, the RUC agreed to directly crosswalk the work RVU of 95908 to CPT code 62270. To justify this value, the RUC noted that the surveyed code has identical intensity to the base code, 95907. Valuing 95908 at the same intensity factor results in a work RVU of 1.37, identical to the reference code. The RUC agreed that this value places 95908 in proper rank order within the family of services and within the RBRVS. **The RUC recommends a work RVU of 1.37 for CPT code 95908.**

95909 5-*6 nerve conduction studies*
The RUC reviewed the survey results from 52 practicing physicians and agreed that the intra-service time for this code did not fit in proper relativity within the family. To determine more accurate intra-service time, the Committee noted that nerve conduction studies are typically done in pairs, thus using the approved physician time from the base code 95907, 15 minutes, the RUC agreed that 7.5 minutes per nerve was a reasonable increment to assess the physician work of 95909. The RUC then conservatively assumed an increase of 1.5 nerves per bundled code, resulting in an additional 10 minutes, from the 3-4 bundled nerve code, of intra-service time for 95909. The recommended physician time components are: pre-service time= 10 minutes, intra-service time= 35 minutes and post-service time= 11 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service.

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The RUC also noted that the survey's estimated work value was overestimated at the median level, 2.28. To determine an appropriate value, the RUC compared the physician work of 95909 to CPT code 95813 *Electroencephalogram (EEG) extended monitoring; greater than 1 hour* (work RVU= 1.73) and agreed that the two services have comparable physician work and physician total time, 60 minutes and 56 minutes, respectively. Given this close comparison, the RUC agreed that the two services should have almost identical work values. To justify this relativity, the RUC noted that the surveyed code has identical intensity to the base code, 95907. Valuing 95909 at the same intensity factor results in a work RVU of 1.77, almost identical to the reference code. The RUC agreed that this value places 95909 in proper rank order within the family of services and within the RBRVS. **The RUC recommends a work RVU of 1.77 for CPT code 95909.**

95910 ***7-8 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 13 minutes, intra-service time= 40 minutes and post-service time= 12.50 minutes. The RUC agreed that pre-service time of 13 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 2.80 is an accurate value for CPT code 95910. To justify this value the RUC compared 95910 to CPT code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 2.40) and agreed that while the reference code has slightly greater total time compared to 95910, 70 minutes and 65.5 minutes, respectively, the surveyed code should be valued higher because it is a more complex and involved procedure. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95910 and arrived at a work value of 2.80. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 2.81 is relative across the RBRVS. **The RUC recommends a work RVU of 2.80 for CPT code 95910.**

95911 ***9-10 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 15 minutes, intra-service time= 50 minutes and post-service time= 15 minutes. The RUC agreed that pre-service time of 15 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

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The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 3.34 is an accurate value for CPT code 95911. To justify this value the RUC compared 95911 to CPT code 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended* (work RVU= 3.08) and agreed that the surveyed code should be valued higher than the reference code because 95911 has five more minutes of intra-service time. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95911 and arrived at a work value of 3.47. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 3.34 is relative across the RBRVS. **The RUC recommends a work RVU of 3.34 for CPT code 95911.**

95912 ***11-12 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 15 minutes, intra-service time= 60 minutes and post-service time= 15 minutes. The RUC agreed that pre-service time of 15 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 4.00 is an accurate value for CPT code 95912. To justify this value the RUC compared 95912 to CPT code 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* (work RVU= 3.50) and agreed that while the two service have identical intra-service time the surveyed code should have a higher value due to greater total time, 90 minutes compared to 70 minutes. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95912 and arrived at a work value of 4.03. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 4.00 is relative across the RBRVS. **The RUC recommends a work RVU of 4.00 for CPT code 95912.**

95913 ***13 or more nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 15 minutes, intra-service time= 70 minutes and post-service time= 20 minutes. The RUC agreed that pre-service time of 15 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

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The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 4.20 is an accurate value for CPT code 95913. To justify this value the RUC compared 95913 to CPT code 95956 *Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse* (work RVU= 3.61) and agreed that the surveyed code should be valued higher due to greater intra-service time, 70 minutes compared to 60 minutes. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95913 and arrived at a work value of 4.70. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 4.20 is relative across the RBRVS. **The RUC recommends a work RVU of 4.20 for CPT code 95913.**

The RUC reviewed the RUC recommendations from April 2011 for the add-on EMG codes 95885 *Needle electromyography each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited*, 95886 *Needle electromyography each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels* and 95887 *Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study* and agreed to reaffirm the established values, as they are relative to the family of services reviewed at the April 2012 RUC meeting. In addition, the RUC reviewed the recent October 2009 RUC recommendation for CPT code 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report* and agreed that the physician work is limited for this service, 5 minutes intra-service time, and would not benefit from an additional review only two cycles later. **The RUC reaffirms a work RVU of 0.35 for CPT code 95885, a work RVU of 0.92 for CPT code 95886, a work RVU of 0.73 for CPT code 95887 and a work RVU of 0.05 for CPT code 95905.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Budget Neutrality: The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Medicine** **Neurology and Neuromuscular Procedures** **Electromyography**				
Needle electromyographic (EMG) procedures include the interpretation of electrical waveforms measured by equipment that produces both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode. Use 95870 or 95885 when four or fewer muscles are tested in an extremity. Use 95860-95864 or 95886 when five or more muscles are tested in an extremity. Use EMG codes (95860-95864 and 95867-95870) when no nerve conduction studies (~~95900-95904~~ 95907-95913) are performed on that day. Use 95885, 95886 and 95887 for EMG services when nerve conduction studies (~~95900-95904~~ 95907-95913) are performed in conjunction with EMG on the same day. Report either 95885 or 95886 once per extremity. Codes 95885 and 95886 can be reported together up to a combined total of four units of service per patient when all four extremities are tested.				
95860	R1	Needle electromyography; 1 extremity with or without related paraspinal areas	XXX	0.96 (No Change)
95861	R2	2 extremities with or without related paraspinal areas (For dynamic electromyography performed during motion analysis studies, see 96002-96003)	XXX	1.54 (No Change)
95863	R3	3 extremities with or without related paraspinal areas	XXX	1.87 (No Change)
95864	R4	4 extremities with or without related paraspinal areas	XXX	1.99 (No Change)

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95865	R5	larynx (Do not report modifier 50 in conjunction with 95865) (For unilateral procedure, report modifier 52 in conjunction with 95865)	XXX	1.57 (No Change)
95866	R6	hemidiaphragm	XXX	1.25 (No Change)
95867	R7	cranial nerve supplied muscle(s), unilateral	XXX	0.79 (No Change)
95868	R8	cranial nerve supplied muscles, bilateral	XXX	1.18 (No Change)
95869	R9	thoracic paraspinal muscles (excluding T1 or T12)	XXX	0.37 (No Change)
95870	R10	limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters (To report a complete study of the extremities, see 95860-95864) (For anal or urethral sphincter, detrusor, urethra, perineum musculature, see 51785-51792) (For eye muscles, use 92265)	XXX	0.37 (No Change)
#✚95885	R11	Needle electromyography each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	ZZZ	0.35 RUC reaffirmed April 2011 Work Values

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#✚ 95886	R12	complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure) (Use 95885, 95886 in conjunction with ~~95900-95904~~ 95907-95913) (Do not report 95885, 95886 in conjunction with 95860-95864, 95870, 95905)	ZZZ	0.92 RUC reaffirmed April 2011 Work Values
#✚95887	R13	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure) (Use 95887 in conjunction with ~~95900-95904~~ 95907-95913) (Do not report 95887 in conjunction with 95867-95870, 95905)	ZZZ	0.73 RUC reaffirmed April 2011 Work Values
Nerve Conduction Tests				

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The following applies to nerve conduction tests (~~95900-95904~~ 95907-95913): Codes ~~95900-95904~~ 95907-95913 describe nerve conduction tests when performed with individually placed stimulating, recording, and ground electrodes. The stimulating, recording, and ground electrode placement and the test design must be individualized to the patient's unique anatomy. Nerves tested must be limited to the specific nerves and conduction studies needed for the particular clinical question being investigated. The stimulating electrode must be placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, and in some sensory and mixed nerve conduction studies, both proximal and distal stimulation will be used. Motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested. Waveforms must be reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) must be adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Reports must be prepared on site by the examiner, and consist of the work product of the interpretation of numerous test results, using well-established techniques to assess the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of each nerve tested. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values, summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation. Codes 95907-95913 describe one or more nerve conduction studies. For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H Reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve and constitutes a distinct study when determining the number of studies in each grouping (eg, 1-2 or 3-4 nerve conduction studies). A nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use. For a list of nerves, see Appendix J. Use 95885-95887 in conjunction with 95907-95913 when performing electromyography with nerve conduction studies.

Code 95905 describes nerve conduction tests when performed with preconfigured electrodes customized to a specific anatomic site.

D⊘95900		~~Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study~~	XXX	N/A
D⊘95903		~~motor, with F-wave study~~	XXX	N/A

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D⊘95904		~~sensory~~ (95900-95904 have been deleted. For nerve conduction studies, see 95907-95913) ~~(Report 95900, 95903, and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded)~~ ~~(Use 95885-95887 in conjunction with 95900-95904 when performing electromyography with nerve conduction studies)~~	XXX	N/A
●95907	R14	1-2 nerve conduction studies	XXX	1.00
●95908	R15	3-4 nerve conduction studies	XXX	1.37
●95909	R16	5-6 nerve conduction studies	XXX	1.77
●95910	R17	7-8 nerve conduction studies	XXX	2.80
●95911	R18	9-10 nerve conduction studies	XXX	3.34
●95912	R19	11-12 nerve conduction studies	XXX	4.00
●95913	R20	13 or more nerve conduction studies	XXX	4.20

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⦸95905	R21	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report (Report 95905 only once per limb studied) (Do not report 95905 in conjunction with 95885, 95886, ~~95900-95904~~ 95907-95913, ~~95934-95936~~)	XXX	0.05 Approved at the October 2009 RUC Meeting

Intraoperative Neurophysiology

Codes 95940, 95941 describe ongoing neurophysiologic monitoring, testing and data interpretation distinct from performance of specific type(s) of baseline neurophysiologic study(s) performed during surgical procedures. When the service is performed by the surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologist's primary service code(s) for the procedure and are not reported separately. Do not report these codes for automated monitoring devices that do not require continuous attendance by a professional qualified to interpret the testing and monitoring.

Recording and testing ~~is~~ are performed either personally or by a technologist who is physically present with the patient during the service. Supervision is performed either in the operating room or by real time connection outside the operating room. The monitoring professional must be solely dedicated to performing the **intraoperative neurophysiologic** monitoring and must be available to intervene at all times during the service as necessary, for the reported time period(s). For any given period of time spent providing these services, the service takes full attention and, therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period of time.

Throughout the monitoring, there must be provisions for continuous and immediate communication directly with the operating room team in the surgical suite. One or more simultaneous cases may be reported **(95941).** When monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual's

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exclusive attention be required for another procedure. Report 95941 for all **remote or non-one on one** monitoring time connected to each case regardless of overlap with other cases**.**

Codes 95940, 95941 include only the ongoing neurophysiologic monitoring time distinct from performance of specific type(s) of baseline neurophysiologic study(s) or other services such as intraoperative functional cortical and subcortical mapping.Codes 95940 and 95941 are reported based upon the time spent monitoring only, and not the number of baseline tests performed or parameters monitored. The time spent performing or interpreting the baseline neurophysiologic study(s) should not be counted as intraoperative monitoring, but represents separately reportable procedures. When reporting 95940 and 95941, the same neurophysiologic study(ies) performed at baseline should be reported not more than once per operative session.

Baseline study reporting is based upon the total unique studies performed. For example, if during the course of baseline testing and one-on-one monitoring, two separate nerves have motor testing performed in conjunction with limited single extremity EMG, then 95985 and 959AX would be reported in addition to 95940. For procedures that last beyond midnight, report services using the day on which the monitoring began and using the total time monitored.

Code 95940 is reported per 15 minutes of service. Code 95940 requires reporting only the portion of time the monitoring professional was physically present in the operating room providing one-on-one patient monitoring, and no other cases may be monitored at the same time. Report continuous intraoperative neurophysiologic monitoring in the operating room (95940) in addition to the services related to monitoring from outside the operating room (95941).

Code 95941 should be used once per hour even if multiple methods of neurophysiologic monitoring are used during the time. Code 95941 requires the monitoring of neurophysiological data that is collected from the operating room continuously on-line in real time via a secure data link. When reporting 95941, real-time ability must be available through sufficient data bandwidth transfer rates to view and interrogate the neurophysiologic data contemporaneously.

Report 95941 for all cases in which there was no physical presence by the monitoring professional in the operating room during the monitoring time **or when monitoring more than one case in an operating room.** It is also used to report the time of monitoring physically performed outside of the operating room in those cases where monitoring occurred both within and outside the operating room. Do not report 95941 if the monitoring lasts 30 minutes or less.

Intraoperative neurophysiology monitoring codes 95940 and 95941 are each used to report the total duration of respective time spent providing each service, even if that time is not in a single continuous block.

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D ✚*95920*		~~Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure~~ ~~(Use 95920 in conjunction with the study performed, 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925 95937)~~ (95920 has been deleted. To report, see 95940, 95941) ~~(Code 95920 describes ongoing electrophysiologic testing and monitoring performed during surgical procedures. Code 95920 is reported per hour of service, and includes only the ongoing electrophysiologic monitoring time distinct from performance of specific type[s] of baseline electrophysiologic study[s] [95860, 95861, 95867, 95868, 95870, 95900, 95904, 95928, 95929, 95933-95937] or interpretation of specific type[s] of baseline electrophysiologic study[s] [92585, 95822, 95870, 95925- 95928, 95929, 95930]. The time spent performing or interpreting the baseline electrophysiologic study[s] should not be counted as intraoperative monitoring, but represents separately reportable procedures. Code 95920 should be used once per hour even if multiple electrophysiologic studies are performed. Do not report 95920 if recording lasts 30 minutes or less. The baseline electrophysiologic study[s] should be used once per operative session. For procedures that last beyond midnight, report services using the day on which the monitoring began and using the total hours monitored)~~	ZZZ	N/A
		~~(For time spent waiting on standy before monitoring, use 99360)~~ ~~(For electrocorticography, use 95829)~~ ~~For intraoperative EEG during nonintracranial surgery, use 95955)~~ ~~(For intraoperative functional cortical or subcortical mapping, see 95961-95962)~~ ~~(For intraoperative neurostimulator programming and analysis, see 95970-95975)~~		

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✚●95940		Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure) (Use 95940 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925-95939)		
✚●95941		Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure) (Use 95941 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925-95939) (For time spent waiting on standby before monitoring, use 99360) (For electrocorticography, use 95829) (For intraoperative EEG during nonintracranial surgery, use 95955) (For intraoperative functional cortical or subcortical mapping, see 95961-95962) (For intraoperative neurostimulator programming and analysis, see 95970-95975)		
Evoked Potentials and Reflex Tests				
D95934		~~H reflex, amplitude and latency study; record gastrocnemius/soleus muscle~~	XXX	N/A
D95936		~~record muscle other than gastrocnemius/soleus muscle~~ ~~(To report a bilateral study, use modifier 50)~~ (95934 and 95936 have been deleted. To report H reflex testing, see 95907-95913)	XXX	N/A
Editorial revisions to guidelines				

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Codes 96000-96004 describe…

Code 96004 should…

(For performance of needle electromyography procedures, see 95860-95870, 95872, 95885-95887 ~~95875~~)

(For gait training, use 97116)

96000 Comprehensive computer-based motion analysis by video-taping and 3D kinematics

96001 with dynamic plantar pressure measurements during walking

96002 Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles

96003 Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle

(Do not report 96002, 96003 in conjunction with 95860-~~95864~~ 95866, 95869-95872, 95885-95887)

Physical Medicine and Rehabilitation
Tests and Measurements

Requires direct one-on-one patient contact.

(For muscle testing, manual or electrical, joint range of motion, electromyography or nerve velocity determination, see

95831-95857, 95860-95872, 95885-95887, 95907-95913 ~~95904~~)

97750 Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Appendix J
Electrodiagnostic Medicine
Listing of Sensory, Motor,

and Mixed Nerves

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This summary assigns each sensory, motor, and mixed nerve with its appropriate nerve conduction study code in order to enhance accurate reporting of codes ~~95900, 95903, and 95904~~ 95907-95913. Each nerve constitutes one unit of service.

Motor Nerves Assigned to Codes 95900 and ~~95903~~ 95907-95913

I. Upper extremity, cervical plexus, and brachial plexus motor nerves

Sensory and Mixed Nerves Assigned to Code ~~95904~~ 95907-95913

I. Upper extremity sensory and mixed nerves

	Type of Study/Maximum Number of Studies				
		Nerve Conduction Studies (~~95900, 95903, 95904~~95907-95913)		**Other EMG Studies (~~95934, 95936,~~ 95907-95913, 95937)**	
Indication	**Needle EMG (95860-95864, 95867-95870)**	***Motor NCS With and/or Without F wave***	***Sensory NCS***	***H-Reflex***	***Neuromuscular Junction Testing (Repetitive Stimulation)***
Carpal Tunnel (Unilateral)	*1*	*3*	*4*	*-*	*-*
Carpal Tunnel (Bilateral)	*2*	*4*	*6*	*-*	*-*
Radiculopathy	*2*	*3*	*2*	*2*	*-*
Mononeuropathy	*1*	*3*	*3*	*2*	*-*
Polyneuropathy/Mononeuropathy Multiplex	*3*	*4*	*4*	*2*	*-*

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Myopathy	*2*	*2*	*2*	*-*	*2*
Motor Neuronopathy (eg, ALS)	*4*	*4*	*2*	*-*	*2*
Plexopathy	*2*	*4*	*6*	*2*	*-*
Neuromuscular Junction	*2*	*2*	*2*	*-*	*3*
Tarsal Tunnel Syndrome (Unilateral)	*1*	*4*	*4*	*-*	*-*
Tarsal Tunnel Syndrome (Bilateral)	*2*	*5*	*6*	*-*	*-*
Weakness, Fatigue, Cramps, or Twitching (Focal)	*2*	*3*	*4*	*-*	*2*
Weakness, Fatigue, Cramps, or Twitching (General)	*4*	*4*	*4*	*-*	*2*
Pain, Numbness, or Tingling (Unilateral)	*1*	*3*	*4*	*2*	*-*
Pain, Numbness, or Tingling (Bilateral)	*2*	*4*	*6*	*2*	*-*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

April 3, 2012

Barbara Levy, M.D.
Chair, Relative Value Scale Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

RE: Tab 32: EMG in Conjunction with Nerve Testing

Dear Dr. Levy:

The American Academy of Neurology (AAN), the American Association of Neuromuscular &Electrodiagnostic Medicine (AANEM), the American Academy of Physical Medicine & Rehabilitation (AAMPR), and the American Physical Therapy Association (APTA) surveyed 17 EMG and nerve testing codes for this meeting.

The following four codes were not surveyed for this meeting because they were recently surveyed and reviewed by the RUC.

- Codes 95885, 95886, 95887 were just reviewed in April 2012. The previous RUC recommendations are included in the attached materials to facilitate the RUC's reaffirmation of these values given the whole family has been reviewed at this meeting.

- Code 95905 was recently reviewed in February 2009. This service has limited physician work and time (work RVU= 0.05 and intra-service time= 5 minutes). The survey in 2009 contained 75 respondents and a new survey three years later would not have gathered better data. Therefore, the previous RUC recommendations are included in the attached materials to facilitate the RUC's reaffirmation of this value given the whole family has been reviewed at this meeting.

The attached spreadsheet shows all the codes in the family and the existing and proposed times and RVUs.

Sincerely,

Marianna Spanaki, MD, PhD
AAN RUC Advisor

Joseph Zuhosky, MD
AAPMR RUC Advisor

Andrea Boon, MD
AANEM Advisor Alternate

John Palazzo, DSc, PT, ECS
APTA Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95860 Tracking Number R1 Original Specialty Recommended RVU: **0.96**
Presented Recommended RVU: **0.96**
Global Period: XXX RUC Recommended RVU: **0.96**

CPT Descriptor: Needle electromyography; 1 extremity with or without related paraspinal areas

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old man injured his right shoulder and has weakness and restricted range of motion of the proximal right upper extremity. Imaging studies demonstrate a rotator cuff tear, but the orthopedic surgeon believes the weakness on exam is out of proportion to these findings, and orders an EMG to evaluate for the presence of a brachial plexopathy, or mononeuropathy such as an axillary neuropathy that could impact decision making regarding the most appropriate course of treatment. Needle electromyography of five or more muscles in the right upper extremity and related cervical paraspinal muscles is indicated to look for signs of active denervation, fasciculations, chronic denervation/reinnervation, and myopathy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intra-service work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the multiple needle insertions. Under minimal voluntary contraction of the muscle 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95860		
Sample Size:	294	**Resp N:** 93	**Response:** 31.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	92.00	**200.00**	381.00	900.00
Survey RVW:	0.35	1.00	**1.25**	2.00	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	120.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95860	**Recommended Physician Work RVU: 0.96**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78707	XXX	0.96	**RUC Time**	19,721

CPT Descriptor 1 Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99213	XXX	0.97	**RUC Time**	100,611,197

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 27.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 95860**	**Key Reference CPT Code:** 99213	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	3.00	
Median Intra-Service Time	20.00	15.00	

Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**40.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.08	3.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.76	2.92
Urgency of medical decision making	2.69	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.17
Physical effort required	2.63	2.57
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.04	1.92
Outcome depends on the skill and judgment of physician	4.04	3.54
Estimated risk of malpractice suit with poor outcome	2.96	2.88

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.24	2.72
Intra-Service intensity/complexity	3.16	2.68
Post-Service intensity/complexity	2.30	2.70

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

These codes describe needle EMG when performed without a nerve study on the same day. This is uncommon and utilization of these codes will be minimal. New add-on codes were created and are effective as of 2012 for EMG when performed on the same day as nerve studies.

For the EMG family, the societies split the 10 EMG codes into two surveys. In order to maintain relativity between the two sets of surveys, code 95860 was in both surveys. The first survey included EMG of 1, 2, 3, and 4 limbs (95860, 95861, 95863, and 95864). The second survey included 95860 as well as EMG codes 95865, 95866, 95867, 95868, 95869, and 95870.

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results.

Code 95860 was included in the survey for the limb EMG codes 95860-95864 as well as the survey for the remaining EMG codes. The data from each survey is included here. The combined data is represented within this summary of recommendation form.

	Pre-time	Intra-time	Post-time	Total Time	Median RVW
95860 in limb survey	7	18	10	35	1.20
95860 in misc. EMG survey	10	20	10	40	1.50
95860 combined data	**10**	**20**	**10**	**40**	**1.25**

The societies recommend that the existing value of 0.96 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/20/10 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95860

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 21056
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 13265 Percentage 62.99 %

Specialty AAPMR Frequency 6527 Percentage 30.99 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,264
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 3316 Percentage 62.99 %

Specialty AAPMR Frequency 1632 Percentage 31.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95860

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95861 Tracking Number R2 Original Specialty Recommended RVU: **1.54**
Presented Recommended RVU: **1.54**
Global Period: XXX RUC Recommended RVU: **1.54**

CPT Descriptor: Needle electromyography; 2 extremities with or without related paraspinal areas

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old woman with a five-month history of marked pain and proximal left lower limb weakness now presents with 3 weeks of severe pain and weakness in the proximal right lower limb. Physical examination shows a cachectic elderly woman with disproportionate wasting of the left more than right thigh muscles. You suspect lumbar plexopathy but also wish to exclude radiculopathy, polyradiculoneuropathy, mononeuritis multiplex, or a myopathy. Needle electromyography of five or more muscles in the two lower extremities and related lumbar paraspinal muscles is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined..

Description of Intra-Service Work: Intra-service work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode in to each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to ensure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle. Five or more muscles are examined individually in each of two limbs using

the steps outlined above. For each of the two limbs examined, the muscles are located in the limb and/or its related cervical or lumbar paraspinal areas, and are innervated by three or more nerves or four or more spinal levels.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95861		
Sample Size:	147	**Resp N:** 46	**Response:** 31.2 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	99.00	**137.50**	262.50	1000.00
Survey RVW:	0.55	1.50	**1.83**	2.10	3.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**29.00**	40.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95861	**Recommended Physician Work RVU: 1.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**29.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99382	XXX	1.60	**RUC Time**	0

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11441	010	1.53	**RUC Time**	55471

CPT Descriptor 2 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 34.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 95861**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	29.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**49.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.31	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.13	3.13
Urgency of medical decision making	3.38	3.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.94	3.38
Physical effort required	3.31	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.56	2.50
Outcome depends on the skill and judgment of physician	4.13	3.56
Estimated risk of malpractice suit with poor outcome	3.06	2.94

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.59	2.57
Intra-Service intensity/complexity	3.41	3.22
Post-Service intensity/complexity	2.74	2.78

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 1.54 be maintained, which is near the survey 25th percentile. We recommend times of 10/29/10 be accepted, which are identical to the survey median times, with the exception of a 0.5 minute increase to the pre-service time to make it standard with the other limb EMG code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95861

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 29120
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 17763 Percentage 60.99 %

Specialty AAPMR Frequency 7862 Percentage 26.99 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,280
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The utilization was provided by the AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 4441 Percentage 61.00 %

Specialty AAPMR Frequency 1966 Percentage 27.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95861

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95863 Tracking Number R3 Original Specialty Recommended RVU: **1.87**
Presented Recommended RVU: **1.87**
Global Period: XXX RUC Recommended RVU: **1.87**

CPT Descriptor: Needle electromyography; 3 extremities with or without related paraspinal areas

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man with a history of IV drug abuse leading to bacterial endocarditis and cervical and lumbar epidural abscess with right arm and bilateral leg weakness is progressing poorly after the cervical and lumbar surgeries to drain the abscesses. It is uncertain if his inability to move his limbs is due to weakness from residual right cervical and bilateral lumbar radiculopathies, polyradiculoneuropathy, mononeuritis multiplex, or is due to pain or psychophysiological factors. Needle EMG of five or more muscles in the right upper extremity and both lower extremities is indicated to look for signs of active denervation, fasciculations, and chronic denervation/reinnervation.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intra-service work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode in to each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to ensure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle. Five or more muscles are examined individually in each of two limbs using

the steps outlined above. For each of the three limbs examined, the muscles are located in the limb and/or its related cervical or lumbar paraspinal areas, and are innervated by three or more nerves or four or more spinal levels.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95863		
Sample Size:	147	**Resp N:** 46	**Response:** 31.2 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	50.00	250.00
Survey RVW:	0.75	1.96	**2.45**	2.90	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**40.00**	50.00	75.00

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95863	**Recommended Physician Work RVU: 1.87**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64449	000	1.81	**RUC Time**	5,482

CPT Descriptor 1 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94002	XXX	1.99	**RUC Time**	17,741

CPT Descriptor 2 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 28.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 95863**	**Key Reference CPT Code:** 99215	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	40.00	35.00	
Median Immediate Post-service Time	11.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**61.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.33	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.72
Urgency of medical decision making	3.94	3.78
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	3.89
Physical effort required	3.67	3.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.72	2.67
Outcome depends on the skill and judgment of physician	4.44	3.94
Estimated risk of malpractice suit with poor outcome	3.17	3.22

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.22	3.20
Intra-Service intensity/complexity	4.24	3.96
Post-Service intensity/complexity	3.61	3.48

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 1.87 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/40/11 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95863

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 572
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 464 Percentage 81.11 %

Specialty AAPMR Frequency 74 Percentage 12.93 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 143
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. The utilization was provided by the AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 115 Percentage 80.41 %

Specialty AAPMR Frequency 18 Percentage 12.58 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95863

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95864 Tracking Number R4 Original Specialty Recommended RVU: **1.99**
Presented Recommended RVU: **1.99**
Global Period: XXX RUC Recommended RVU: **1.99**

CPT Descriptor: Needle electromyography; 4 extremities with or without related paraspinal areas

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old man with weakness and wasting is referred for a second opinion to rule out motor neuron disease, multifocal motor neuropathy, polyradiculoneuropathy, or myopathy. Earlier nerve conduction studies were normal and needle EMG studies were equivocal. The patient has progressively gotten weaker. Needle EMG of five or more muscles in all four limbs and related paraspinal muscles is indicated to look for signs of active denervation, fasciculations, chronic denervation/reinnervation, and myopathy.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the history and notes in particular if there is any history of reaction to local anesthesia -- if this will be used. The indications, risks, and potential complications are explained in detail, the latter including respiratory mucosal irritation, bleeding, and laryngeal edema necessitating intubation. In addition, the procedures which may need to be performed in event of respiratory insufficiency (including emergency chest x-ray, airway or endotracheal tube placement, and hospitaliztion) are discussed. Informed consent is obtained.

Description of Intra-Service Work: The needle electrode is inserted through the skin, then the cricothyroid membrane until muscle activity is located. Placement can be confirmed by phonation of high-pitched vowels. Activation of neck strap muscles without phonation should produce no EMG activity. The muscles being studied are quite small and swallowing or coughing may displace the needle. Localization is often prolonged, particularly in circumstances of vocal fold paresis or paralysis, as phonation to assist localization may not be possible. When the correct muscles are identified, electrodiagnostic properties of the muscle are reviewed including insertional activity, spontaneous activity, and voluntary motor unit potential activity. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle.After the appropriate muscles have been localized and evaluated, the needle is withdrawn, and direct pressure is applied to prevent bleeding.

Description of Post-Service Work: The patient is observed and queried regarding respiratory symptoms. If stridor or dyspnea is reported, the patient is examined. If necessary the resuscitation team is called for consideration of endotracheal intubation. The patient is instructed what to do should respiratory symptoms develop in the hours or days following the laryngeal EMG. Post-service work includes summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95864		
Sample Size:	147	**Resp N:** 46	**Response:** 31.2 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**9.00**	20.00	800.00
Survey RVW:	1.00	2.36	**2.68**	3.51	5.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	37.00	**50.00**	60.00	90.00

Immediate Post Service-Time:	**13.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95864	**Recommended Physician Work RVU: 1.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**13.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95810	XXX	2.50	**RUC Time**

CPT Descriptor Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78812	XXX	1.93	**RUC Time**	23,981

CPT Descriptor 1 Positron emission tomography (PET) imaging; skull base to mid-thigh

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11423	010	2.06	**RUC Time**	17,728

CPT Descriptor 2 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 39.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 95864**	**Key Reference CPT Code:** 95810	**Source of Time**
Median Pre-Service Time	10.00	15.00	
Median Intra-Service Time	50.00	36.50	
Median Immediate Post-service Time	13.50	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**73.50**	**66.50**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.69	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.63	4.13
Urgency of medical decision making	4.38	3.94
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.56	3.94
Physical effort required	4.50	3.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.81	2.50
Outcome depends on the skill and judgment of physician	4.75	4.13
Estimated risk of malpractice suit with poor outcome	3.69	3.44

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.78	3.61
Intra-Service intensity/complexity	4.80	4.48
Post-Service intensity/complexity	4.20	4.04

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 1.99 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/50/13.5 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95864

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 728
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 473 Percentage 64.97 %

Specialty AAPMR Frequency 124 Percentage 17.03 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 182
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The utilization was provided by the AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 118 Percentage 64.83 %

Specialty AAPMR Frequency 31 Percentage 17.03 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95864

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95865 Tracking Number R5 Original Specialty Recommended RVU: **1.57**
Presented Recommended RVU: **1.57**
Global Period: XXX RUC Recommended RVU: **1.57**

CPT Descriptor: Needle electromyography; larynx

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36 year old man complains of a raspy voice after being intubated for a number of days following a drug induced coma. The condition does not improve two months after the hospitalization. His otolaryngologist is uncertain if the cord has a mechanical problem or has sustained damage to its peripheral innervation. He requests EMG for laryngeal muscle assessment.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the history and notes in particular if there is any history of reaction to local anesthesia -- if this will be used. The indications, risks, and potential complications are explained in detail, the latter including respiratory mucosal irritation, bleeding, and laryngeal edema necessitating intubation. In addition, the procedures which may need to be performed in event of respiratory insufficiency (including emergency chest x-ray, airway or endotracheal tube placement, and hospitaliztion) are discussed. Informed consent is obtained.

Description of Intra-Service Work: The needle electrode is inserted through the skin, then the cricothyroid membrane until muscle activity is located. Placement can be confirmed by phonation of high-pitched vowels. Activation of neck strap muscles without phonation should produce no EMG activity. The muscles being studied are quite small and swallowing or coughing may displace the needle. Localization is often prolonged, particularly in circumstances of vocal fold paresis or paralysis, as phonation to assist localization may not be possible. When the correct muscles are identified, electrodiagnostic properties of the muscle are reviewed including insertional activity, spontaneous activity, and voluntary motor unit potential activity. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle.After the appropriate muscles have been localized and evaluated, the needle is withdrawn, and direct pressure is applied to prevent bleeding.

Description of Post-Service Work: The patient is observed and queried regarding respiratory symptoms. If stridor or dyspnea is reported, the patient is examined. If necessary the resuscitation team is called for consideration of endotracheal intubation. The patient is instructed what to do should respiratory symptoms develop in the hours or days following the laryngeal EMG. Post-service work includes summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS				
Specialty(s):	AAN, AANEM, AAPMR, APTA				
CPT Code:	95865				
Sample Size:	194	**Resp N:**	26	**Response:** 13.4 %	
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	2.00	200.00
Survey RVW:	0.45	1.05	**1.55**	2.00	5.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**6.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95865	**Recommended Physician Work RVU: 1.57**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**6.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77290	XXX	1.56	**RUC Time**	334,547

CPT Descriptor 1 Therapeutic radiology simulation-aided field setting; complex

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99382	XXX	1.60	**RUC Time**	0

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 23.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95865**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	6.50	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**31.50**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.20
Urgency of medical decision making	3.60	2.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.50	3.75
Physical effort required	3.33	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.25	3.75
Outcome depends on the skill and judgment of physician	4.25	3.75
Estimated risk of malpractice suit with poor outcome	3.50	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.52	2.92
Intra-Service intensity/complexity	4.57	3.75
Post-Service intensity/complexity	3.17	3.08

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies noted the survey data is only based on 26 responses because this code is provided by a much smaller subset of providers and had utilization of less than 1200 for Medicare in 2010. The societies recommend that the existing value of 1.57 be maintained, which is near the median RVW of 1.55. The societies also recommend increasing the post-service time to 10 minutes to match that of 95866. We recommend times of 10/15/10 be accepted. This service warrants a higher value than 95866 because it is much more intense and there is more risk working near the larynx.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95865

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4768
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. TWe estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 2239 Percentage 46.95 %

Specialty AAO-HNS Frequency 2049 Percentage 42.97 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,191
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 560 Percentage 47.01 %

Specialty AAO-HNS Frequency 512 Percentage 42.98 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95865

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95866 Tracking Number R6 Original Specialty Recommended RVU: **1.25**
Presented Recommended RVU: **1.25**
Global Period: XXX RUC Recommended RVU: **1.25**

CPT Descriptor: Needle electromyography; hemidiaphragm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59 year old woman who has a 50 pack year history of smoking develops painless weakness of intrinsic hand muscles on both sides, fasciculations of upper and lower limb muscles, and shortness of breath. Her physical examination shows diffuse weakness of upper more than lower limb muscle groups, widespread fasciculations, and hyperreflexia. The clinician suspects ALS but wishes to know whether her dyspnea is due to COPD or to involvement of the diaphragm in her neuromuscular disorder which might improve with positive pressure assisted ventilation (BiPAP). She refers the patient for EMG/NCS which includes needle EMG examination of the diaphragm.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the history and notes in particular if the chest x-ray shows hyperexpansion and flat hemidiaphragms which makes the procedure relatively contraindicated and much more risky. The indications, risks, and potential complications are explained in detail, the latter including pneumothorax, bleeding, and infection. In addition, the procedures which may need to be performed in event of pneumothorax, including emergency chest x-ray, chest tube placement, respiratory support, and hospitalization, are discussed. Informed consent is obtained.

Description of Intra-Service Work: Ground and reference electrodes are attached. Localization is performed by palpating the lower costal margin and inserting the EMG needle either in a lower intercostal space, between the ribs, through the two layers of intercostal muscles and in to the diaphragm, or inferior to the costal margin, through the abdominal fascia, and abdominal wall muscles into the costal insertion of the diaphragm where muscle electrical activity is encountered. The patient may need to temporarily be taken off of the ventilator if he/she is intubated. Electrical activity of the muscle is evaluated both with breathing and during silent periods. In some instances, particularly when the patient is comatose, an assistant may need to stimulate the phrenic nerve percutaneously to activate motor unit potentials. Once the diaphragm is localized, electrodiagnostic properties of the muscle are identified including insertional activity, spontaneous activity, and voluntary motor unit potential activity. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal.After the

data is collected and analyzed, the needle is withdrawn. In some circumstances, a post-procedure chest x-ray may be desired to exclude pneumothorax, or pneumoperitoneum.

Description of Post-Service Work: The patient is observed and queried regarding respiratory symptoms. If increased dyspnea is reported, the posterior chest is auscultated. If decreased breath sounds are apparent, urgent chest x-ray is arranged. The patient is instructed what to do should worsening respiratory symptoms develop in the hours or days following the diaphragm EMG. Post-service work includes summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95866		
Sample Size:	194	**Resp N:** 27	**Response:** 13.9 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	3.50	50.00
Survey RVW:	0.75	1.34	**1.90**	2.23	6.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95866	**Recommended Physician Work RVU: 1.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	16,473

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74160	XXX	1.27	**RUC Time**	2,236,657

CPT Descriptor 2 Computed tomography, abdomen; with contrast material(s)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 95866**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.00
Urgency of medical decision making	4.67	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.83	3.50
Physical effort required	3.33	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.67	3.67
Outcome depends on the skill and judgment of physician	4.50	4.00
Estimated risk of malpractice suit with poor outcome	4.00	3.17

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.44	2.96
Intra-Service intensity/complexity	4.44	3.85
Post-Service intensity/complexity	3.04	3.04

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies noted the survey data is only based on 27 responses because this code is provided by a much smaller subset of providers and had utilization of only 233 for Medicare in 2010. The societies recommend that the existing value of 1.25 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/15/10 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95866

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty ACCP How often? Sometimes

Specialty AAPMR How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 932
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAM Frequency 792 Percentage 84.97 %

Specialty ACCP Frequency 103 Percentage 11.05 %

Specialty AAPMR Frequency 37 Percentage 3.96 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 233
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 198 Percentage 84.97 %

Specialty ACCP Frequency 26 Percentage 11.15 %

Specialty AAPME Frequency 9 Percentage 3.86 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95866

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95867 Tracking Number R7 Original Specialty Recommended RVU: **0.79**
Presented Recommended RVU: **0.79**
Global Period: XXX RUC Recommended RVU: **0.79**

CPT Descriptor: Needle electromyography; cranial nerve supplied muscle(s), unilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman with right-sided Bell's palsy has had little if any clinical return of motor function for four months. The initial needle EMG showed no recruitable motor units in right-sided facial muscles. Surgical procedures to help her close her right eye to prevent corneal drying and abrasion are being considered. Needle EMG of multiple right facial muscles is indicated to look for the appearance of nascent motor units indicative of the beginning of motor recovery.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intraservice work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the needle EMG test with the patient, and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional must specifically assess the risk of the procedure (eg, bleeding, infection, damage to vital organs) by reviewing the patient's medical history and medications. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Once the needle is inserted in to the muscle of interest, electrodiagnostic properties of the muscle are identified including insertional activity, spontaneous activity, and voluntary motor unit potential activity. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal.. The patient is examined after the needle is withdrawn from each puncture site to ensure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Cranial nerve

innervated muscles (eg, face or tongue muscles) on one side of the body are examined individually using the steps outlined above. Special care must be taken during the study since many muscles are thin and located adjacent to critical structures (eg, eye, trachea, lung). Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95867		
Sample Size:	194	**Resp N:** 39	**Response:** 20.1 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**20.00**	50.00	500.00
Survey RVW:	0.40	0.81	**1.15**	1.97	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	15.00	40.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95867	**Recommended Physician Work RVU: 0.79**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29075	000	0.77	**RUC Time**	72,132

CPT Descriptor 1 Application, cast; elbow to finger (short arm)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20610	000	0.79	**RUC Time**	5,973,805

CPT Descriptor 2 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 15.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 95867**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.50	3.17
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.40
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	3.20
Outcome depends on the skill and judgment of physician	4.40	3.60
Estimated risk of malpractice suit with poor outcome	2.80	2.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.03	2.81
Intra-Service intensity/complexity	3.83	3.50
Post-Service intensity/complexity	3.12	3.14

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 0.79 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/15/10 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95867

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 156
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 140 Percentage 89.74 %

Specialty AAPMR Frequency 9 Percentage 5.76 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 39 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 35 Percentage 89.74 %

Specialty AAPMR Frequency 2 Percentage 5.12 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95867

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95868 Tracking Number R8 Original Specialty Recommended RVU: **1.18**
Presented Recommended RVU: **1.18**
Global Period: XXX RUC Recommended RVU: **1.18**

CPT Descriptor: Needle electromyography; cranial nerve supplied muscles, bilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old woman has dysphagia and nasal dysarthria. Motor neuron disease and myopathy is in the differential diagnosis. Needle EMG of multiple bilateral facial and tongue muscles is indicated to look for signs of active denervation, fasciculations, chronic denervation/reinnervation, and myopathy.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intraservice work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the needle EMG test with the patient, and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional must specifically assess the risk of the procedure (eg, bleeding, infection) by reviewing the patient's medical history and medications. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Once the needle is inserted in to the muscle of interest, electrodiagnostic properties of the muscle are identified including insertional activity, spontaneous activity, and voluntary motor unit potential activity. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to ensure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Cranial nerve innervated muscles (eg, face or tongue muscles) on both sides of the body are examined individually using the steps outlined above. Special care must be taken during the study since many muscles are thin and located adjacent to critical structures (eg, eye, trachea,

lung). Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95868		
Sample Size:	194	**Resp N:** 40	**Response:** 20.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**10.00**	20.00	400.00
Survey RVW:	0.71	1.20	**1.50**	2.25	5.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	16.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95868	**Recommended Physician Work RVU: 1.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
56605	000	1.10	**RUC Time**	27,176

CPT Descriptor 1 Biopsy of vulva or perineum (separate procedure); 1 lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99238	XXX	1.28	**RUC Time**	4,979,896

CPT Descriptor 2 Hospital discharge day management; 30 minutes or less

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95868**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**40.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.50
Urgency of medical decision making	3.63	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.38	3.71
Physical effort required	3.50	3.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.63	3.00
Outcome depends on the skill and judgment of physician	4.50	3.75
Estimated risk of malpractice suit with poor outcome	3.63	3.13

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.17	2.92
Intra-Service intensity/complexity	4.09	3.67
Post-Service intensity/complexity	3.35	3.12

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 1.18 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/20/10 be accepted. Code 95868 is the bilateral version of 95867 and the times and RVW increase appropriately relative to that service. There is an increase of 5 minutes intra-service time and a 50% increase in RVW.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95868

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAO-HNS How often? Commonly

Specialty AAPMR How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 104
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 74 Percentage 71.15 %

Specialty AAO-HNS Frequency 18 Percentage 17.30 %

Specialty AAPMR Frequency 6 Percentage 5.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 26 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day. .

Specialty AAN Frequency 18 Percentage 69.23 %

Specialty AAO-HNS Frequency 4 Percentage 15.38 %

Specialty AAPMR Frequency 1 Percentage 3.84 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95868

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95869 Tracking Number R9 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man with four-limb weakness thought originally to have multilevel cervical and lumbar radiculopathies is being evaluated to see if he actually has amyotrophic lateral sclerosis. The thoracic spine is normal on imaging studies. Needle EMG of multiple bilateral thoracic paraspinal muscles is indicated to look for signs of active denervation, fasciculations, and chronic denervation/reinnervation, myopathy, and complex repetitive discharges.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intra-service work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode in to each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the multiple needle insertions. Once the needle is inserted in to the muscle of interest, electrodiagnostic properties of the muscle are identified including insertional activity, spontaneous activity, and voluntary motor unit potential activity. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to ensure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95869		
Sample Size:	194	**Resp N:** 43	**Response:** 22.1 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**18.00**	35.00	250.00
Survey RVW:	0.25	0.50	**1.16**	1.71	5.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	19.00	50.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95869	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,162,922

CPT Descriptor 2 Fundus photography with interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 95869**	**Key Reference CPT Code:** 99213	**Source of Time**
Median Pre-Service Time	10.00	3.00	**RUC Time**
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	4.00
Urgency of medical decision making	3.71	3.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.50
Physical effort required	3.14	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.14	3.17
Outcome depends on the skill and judgment of physician	4.14	4.00
Estimated risk of malpractice suit with poor outcome	3.43	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.82	2.66
Intra-Service intensity/complexity	3.49	3.39
Post-Service intensity/complexity	2.95	2.89

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 0.37 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/15/10 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95869

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 244
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 192 Percentage 78.68 %

Specialty AAPMR Frequency 39 Percentage 15.98 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 61 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day.

Specialty AAN Frequency 48 Percentage 78.68 %

Specialty AAPMR Frequency 10 Percentage 16.39 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95869

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95870 Tracking Number R10 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old man presents with an isolated head drop, the inability to extend his neck. The differential diagnosis includes motor neuron disease, myasthenia gravis, and polymyositis. Needle EMG of several bilateral cervical paraspinal muscles is indicated to look for signs of active denervation, fasciculations, chronic denervation/reinnervation, and myopathy.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician or other qualified health care professional considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intra-service work includes physician or other qualified health care professional participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. The physician or other qualified health care professional places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode in to each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to ensure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Each muscle is graded for insertional/spontaneous activity and voluntary motor unit potential characteristics before proceeding to examine the next muscle. Four or fewer muscles are examined individually using the steps outlined above. The muscles are located in an upper or lower extremity and its related cervical or lumbar paraspinal areas.

Description of Post-Service Work: Post-service work involves summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95870		
Sample Size:	194	**Resp N:** 43	**Response:** 22.1 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**18.00**	35.00	250.00
Survey RVW:	0.40	0.53	**1.00**	1.85	3.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95870	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,162,922

CPT Descriptor 2 Fundus photography with interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 26.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 95870**	**Key Reference CPT Code:** 99213	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	3.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.90
Urgency of medical decision making	2.91	2.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.90	2.67
Physical effort required	2.78	2.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.30	2.22
Outcome depends on the skill and judgment of physician	4.00	3.89
Estimated risk of malpractice suit with poor outcome	2.60	2.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.88	2.66
Intra-Service intensity/complexity	3.48	3.29
Post-Service intensity/complexity	2.95	2.95

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The societies recommend that the existing value of 0.37 be maintained, which is below the survey 25th percentile. We also recommend the survey times of 10/15/10 be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95870

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2452
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 1667 Percentage 67.98 %

Specialty AAPMR Frequency 638 Percentage 26.01 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 613
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This utilization was provided by AMA staff and reflects the service provided only when no nerve conduction study is performed on the same day. .

Specialty AAN Frequency 417 Percentage 68.02 %

Specialty AAPMR Frequency 159 Percentage 25.93 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95870

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95907 Tracking Number R14 Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: XXX RUC Recommended RVU: **1.00**

CPT Descriptor: 1-2 nerve conduction studies; (95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman with a history of proximal median nerve injury secondary to I.V. line placement is referred back to your lab 6 months after initial study. Repeat testing is requested to evaluate recovery.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated.

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test design changes during the course of the study in response to the information obtained. 1-2 nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95907		
Sample Size:	195	**Resp N:** 52	**Response:** 26.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	28.00	**100.00**	155.00	600.00
Survey RVW:	0.30	0.53	**1.00**	1.96	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	55.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95907	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.48	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99213	XXX	0.97	**RUC Time**	100,611,197

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78315	XXX	1.02	**RUC Time**	99,002

CPT Descriptor 2 Bone and/or joint imaging; 3 phase study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 26.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 95907**	**Key Reference CPT Code:** 99212	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	2.00	
Median Intra-Service Time	15.00	10.00	
Median Immediate Post-service Time	10.00	4.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**16.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.64	1.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.79	1.57
Urgency of medical decision making	1.86	1.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.00	1.57
Physical effort required	1.64	1.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.57	1.50
Outcome depends on the skill and judgment of physician	2.79	2.00
Estimated risk of malpractice suit with poor outcome	1.93	1.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.36	1.29
Intra-Service intensity/complexity	1.86	1.71
Post-Service intensity/complexity	1.57	1.57

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This new family of codes replaces existing nerve conduction codes that described motor and sensory nerve conduction studies (95900, 95903, 95904) and H-reflex studies (95934, 95936). Where previously multiple combinations of codes would have been reported for a single patient, now one new code will be reported to describe any combination of nerve studies provided in one visit.

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. They noted that while the times seemed accurate for the lower level codes (95907-09), once respondents started responding for 7 or 9 and more studies on a day, the intra-service times appear low. This may be because the vast majority of practitioners provide fewer than 9 studies on a patient and estimating times for providing 9-10, 11-12, or 13 or more studies is theoretical rather than based on actual practice.

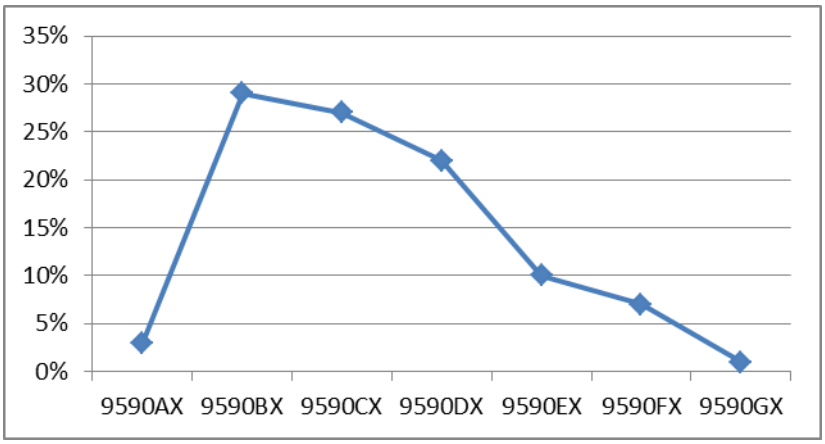
Furthermore, in patients that require higher numbers of nerve conduction studies, they are sicker and have greater pathology meaning that the nerve conduction studies are technically much more difficult to perform as responses are often low amplitude or absent, or unusual studies that are not performed on a daily basis may be indicated, all of which adds considerable time to each study. When respondents replied, they may have considered how long it takes to do a single nerve conduction study and then tried to estimate doing that multiple times, not reflecting the increased complexity and technical difficulty that comes in to play in the more extensive studies requiring many nerves to be studied.

To establish appropriate times for the higher number of studies, the expert panel calculated how many minutes of intra-service times are currently being provided according to the existing nerve conduction codes as approved by RUC in April 2011. The panel determined a weighted average intra-service time (95900 – 6 minutes, 95903 – 10 minutes, 95904 – 5 minutes), taking into account utilization, is 6.70 minutes.

The panel recommends these calculated times for codes 95910-13:

Code	**Studies**	**Time**
95910	7-8	6.70 min. * 7.5 studies = 50.25 min.
95911	9-10	6.70 min. * 9.5 studies = 63.65 min.
95912	11-12	6.70 min. * 11.5 studies = 77.05 min.
95913	13+	6.70 min. * 13 studies = 87.10 min.

The estimated utilization of the codes in this family will be:



Code – Descriptor	Percentage Utilization
95907 1-2 nerve conduction studies	3%
95908 3-4 nerve conduction studies	29%
95909 5-6 nerve conduction studies	28%
95910 7-8 nerve conduction studies	22%
95911 9-10 nerve conduction studies	10%
95912 11-12 nerve conduction studies	7%
9590FG 13 or more nerve conduction studies	1%

Based on the recommended RVUs, the panel reviewed several typical patient scenarios and compared the total RVUs under the current system to the new system.

Current Scenario	95903 Motor w/ F-wave	95900 Motor w/o F wave	95904 Sensory	RVU		New Scenario	Recommended RVU	Difference
Scenario E (9 studies)	2	3	4	3.82		95911 9-10 studies	3.34	-12.57%
Scenario E (10 studies)	3	3	4	4.42				-24.43%
Scenario F (11 studies)	3	1	6	4.26		95912 11-12 studies	4.00	-6.10%
Scenario F (12 studies)	4	1	6	4.86				-17.70%
Scenario G (13 studies)	3	3	7	5.44		95913 13+ studies	4.20	-22.79%
Scenario G (14 studies)	4	3	7	6.04				-30.46%

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 601396
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 312726 Percentage 52.00 %

Specialty AAMPR Frequency 120279 Percentage 19.99 %

Specialty ACP Frequency 48112 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150,349 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes.

Specialty AAN Frequency 78181 Percentage 51.99 %

Specialty AAPMR Frequency 30070 Percentage 20.00 %

Specialty ACP Frequency 12028 Percentage 8.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95908 Tracking Number R15 Original Specialty Recommended RVU: **1.68**
Presented Recommended RVU: **1.68**
Global Period: XXX RUC Recommended RVU: **1.37**

CPT Descriptor: 3-4 nerve conduction studies;(95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old woman with nocturnal paresthesias is referred for evaluation of possible carpal tunnel syndrome. She is referred for nerve conduction testing.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated.

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test design changes during the course of the study in response to the information obtained. 3-4 nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, James Selwa, MD, MBA, PhD, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95908		
Sample Size:	195	**Resp N:** 52	**Response:** 26.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	28.00	**100.00**	155.00	600.00
Survey RVW:	0.20	1.00	**1.68**	2.54	5.78
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	15.00	**22.00**	30.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95908	**Recommended Physician Work RVU: 1.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99382	XXX	1.60	**RUC Time**	0

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99375	XXX	1.73	**RUC Time**	0

CPT Descriptor 2 Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 26.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 95908**	**Key Reference CPT Code:** 99213	**Source of Time RUC Time**
Median Pre-Service Time	10.00	3.00	

Median Intra-Service Time	25.00	15.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**45.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.53
Urgency of medical decision making	2.47	2.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.13	2.73
Physical effort required	2.47	2.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.87	1.87
Outcome depends on the skill and judgment of physician	3.73	3.13
Estimated risk of malpractice suit with poor outcome	2.93	2.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.36	2.20
Intra-Service intensity/complexity	2.71	2.53
Post-Service intensity/complexity	2.50	2.36

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The expert panel observed that only 65% of respondents agreed with the typical patient and noted that many providers may do more than 3-4 studies for carpal tunnel.

The panel estimates this code will constitute 29% of the utilization of the new nerve testing family.

The panel agreed with the survey values and recommends the median RVU of 1.68 and survey times of 10/22/10.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2491496

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 1295578 Percentage 52.00 %

Specialty AAPMR Frequency 498299 Percentage 19.99 %

Specialty ACP Frequency 199320 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 622,874 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes.

Specialty AAN Frequency 323894 Percentage 51.99 %

Specialty AAPMR Frequency 12457 Percentage 1.99 %

Specialty ACP Frequency 49830 Percentage 8.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95909 Tracking Number R16 Original Specialty Recommended RVU: **2.28**
Presented Recommended RVU: **2.28**
Global Period: XXX RUC Recommended RVU: **1.77**

CPT Descriptor: 5-6 nerve conduction studies; (95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old diabetic man is referred for further evaluation of progressive numbness, tingling, and pain in the feet, worse at night, and progressive balance difficulties. Evaluation for peripheral neuropathy vs. polyradiculoneuropathy is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated.

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test

design changes during the course of the study in response to the information obtained. 5-6 nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, James Selwa, MD, MBA, PhD, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95909		
Sample Size:	195	**Resp N:** 52	**Response:** 26.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	60.00	**110.00**	200.00	600.00
Survey RVW:	0.35	1.50	**2.28**	3.53	9.08
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	24.00	**30.00**	40.00	75.00

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95909	**Recommended Physician Work RVU: 1.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.d

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52000	000	2.23	**RUC Time**	908,545

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99386	XXX	2.33	**RUC Time**	1

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 26.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 95909**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	35.00	25.00	
Median Immediate Post-service Time	11.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**56.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.21	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.36
Urgency of medical decision making	2.93	2.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.79	3.43
Physical effort required	3.07	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.43	2.57
Outcome depends on the skill and judgment of physician	4.07	3.57
Estimated risk of malpractice suit with poor outcome	3.21	3.07

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.86
Intra-Service intensity/complexity	3.15	3.00
Post-Service intensity/complexity	3.00	2.86

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The panel estimates this code will constitute 28% of the utilization of the new nerve testing family. The panel agreed with the survey values and recommends the median RVU of 2.28 and survey times of 10/30/11.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAMPR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1530824
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 796028 Percentage 51.99 %

Specialty AAPMR Frequency 306165 Percentage 20.00 %

Specialty ACP Frequency 122466 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 382,706 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes.

Specialty AAN Frequency 199007 Percentage 51.99 %

Specialty AAPMR Frequency 76541 Percentage 19.99 %

Specialty ACP Frequency 30616 Percentage 7.99 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95910 Tracking Number R17 Original Specialty Recommended RVU: **2.90**
Presented Recommended RVU: **2.90**
Global Period: XXX RUC Recommended RVU: **2.80**

CPT Descriptor: 7-8 nerve conduction studies; (95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old female typist is referred for further evaluation of bilateral upper limb numbness and tingling that occurs during the day at work but can also wake her from sleep at times. The symptoms are described as affecting the entire hand and progressing up to the elbow when severe. Nerve conduction studies are indicated to evaluate for carpal tunnel syndrome versus ulnar neuropathy, brachial plexopathy, or cervical radiculopathy.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated.

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test

design changes during the course of the study in response to the information obtained. 7-8 nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS		
Specialty(s):	AAN, AANEM, AAPMR, APTA		
CPT Code:	95910		
Sample Size:	195	**Resp N:** 52	**Response:** 26.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	47.50	**100.00**	200.00	1260.00
Survey RVW:	0.45	2.00	**2.80**	4.00	12.38
Pre-Service Evaluation Time:			**13.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	29.00	**40.00**	50.00	85.00

Immediate Post Service-Time:	**12.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95910	**Recommended Physician Work RVU: 2.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**0.00**	**13.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**12.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
12052	010	2.87	**RUC Time**	75,927

CPT Descriptor 1 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99465	XXX	2.93	**RUC Time**	1

CPT Descriptor 2 Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95910**	**Key Reference CPT Code:** 99215	**Source of Time** **RUC Time**
Median Pre-Service Time	13.00	5.00	
Median Intra-Service Time	40.00	35.00	
Median Immediate Post-service Time	12.50	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**65.50**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.69
Urgency of medical decision making	3.46	3.23
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.23	3.54
Physical effort required	3.62	3.23
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.77	2.69
Outcome depends on the skill and judgment of physician	4.15	3.54
Estimated risk of malpractice suit with poor outcome	3.15	3.15

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.15	2.85
Intra-Service intensity/complexity	3.85	3.38
Post-Service intensity/complexity	3.46	3.38

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The panel estimates this code will constitute 22% of the utilization of the new nerve testing family.

The panel noted the intra-service time appeared too low to perform 7-8 studies and calculated the existing average nerve study intra-service time of 6.70 minutes times 7.5 studies to come up with 50.25 minutes.

The expert panel identified existing code 12007 with 35 intra-service minutes and 2.90 as a crosswalk. The panel recommends an RVU of 2.90 and times of 13/50/12.5.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 882048
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate

Specialty AAN Frequency 458665 Percentage 52.00 %

Specialty AAPMR Frequency 176410 Percentage 20.00 %

Specialty ACP Frequency 70564 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 220,512 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes

Specialty AAN Frequency 114666 Percentage 51.99 %

Specialty AAPMR Frequency 44102 Percentage 19.99 %

Specialty ACP Frequency 17641 Percentage 8.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95911 Tracking Number R18 Original Specialty Recommended RVU: **3.44**
Presented Recommended RVU: **3.44**
Global Period: XXX RUC Recommended RVU: **3.34**

CPT Descriptor: 9-10 nerve conduction studies;(95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old man who was involved in a snow mobile accident 2 months earlier, and now has a flail right upper limb, is referred for further evaluation of traumatic brachial plexopathy.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated.

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test design changes during the course of the study in response to the information obtained. 9-10 nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS				
Specialty(s):	AAN, AANEM, AAPMR, APTA				
CPT Code:	95911				
Sample Size:	195	**Resp N:**	52	**Response:** 26.6 %	
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	105.00	1080.00
Survey RVW:	0.50	2.50	**3.34**	4.50	15.68
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	34.00	**50.00**	60.00	95.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95911	**Recommended Physician Work RVU: 3.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11643	010	3.42	**RUC Time**	47,757

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	121,058

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 17.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 95911**	**Key Reference CPT Code:** 99215	**Source of Time** **RUC Time**
Median Pre-Service Time	15.00	5.00	
Median Intra-Service Time	50.00	35.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**80.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.67
Urgency of medical decision making	3.67	3.44
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	4.00
Physical effort required	4.00	3.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.89	3.11
Outcome depends on the skill and judgment of physician	4.67	4.00
Estimated risk of malpractice suit with poor outcome	4.00	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.78
Intra-Service intensity/complexity	4.00	3.44
Post-Service intensity/complexity	3.25	2.89

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The panel estimates this code will constitute 10% of the utilization of the new nerve testing family. The panel noted the intra-service time appeared too low to perform 9-10 studies and calculated the existing average nerve study intra-service time of 6.70 minutes times 9.5 studies to come up with 63.65 minutes.

The expert panel identified existing code 59012 at 44 intra service and 91 total minutes and 3.44 RVU as a crosswalk. The panel recommends an RVU of 3.44 and times of 15/64/15.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 316524
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 164592 Percentage 51.99 %

Specialty AAPMR Frequency 63305 Percentage 20.00 %

Specialty ACP Frequency 25322 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 79,131 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes.

Specialty AAN Frequency 41148 Percentage 51.99 %

Specialty AAPMR Frequency 15826 Percentage 19.99 %

Specialty ACP Frequency 6331 Percentage 8.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95912 Tracking Number R19 Original Specialty Recommended RVU: **4.10**
Presented Recommended RVU: **4.10**
Global Period: XXX RUC Recommended RVU: **4.00**

CPT Descriptor: 11-12 nerve conduction studies; (95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old diabetic woman with a 3-month history of pain, numbness, and weakness progressively involving different peripheral nerve distributions is referred, with the question of mononeuritis multiplex secondary to vasculitis.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test

design changes during the course of the study in response to the information obtained. 11-12 nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS				
Specialty(s):	AAN, AANEM, AAPMR, APTA				
CPT Code:	95912				
Sample Size:	195	**Resp N:**	52	**Response:**	26.6 %
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**27.50**	71.25	360.00
Survey RVW:	0.70	3.00	**4.00**	5.70	18.98
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	30.00	40.00	**60.00**	70.00	105.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95912	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99245	XXX	3.77	**RUC Time**

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	11,496,708

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11644	010	4.34	**RUC Time**	16,269

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 23.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95912**	**Key Reference CPT Code:** 99245	**Source of Time** RUC Time
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	60.00	60.00	

Median Immediate Post-service Time	15.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**90.00**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.45
Urgency of medical decision making	3.82	3.64
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.55	3.45
Physical effort required	4.18	3.18
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.64	3.09
Outcome depends on the skill and judgment of physician	4.45	3.82
Estimated risk of malpractice suit with poor outcome	3.91	3.36

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.18	2.73
Intra-Service intensity/complexity	4.45	3.64
Post-Service intensity/complexity	3.64	3.09

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The panel estimates this code will constitute 7% of the utilization of the new nerve testing family.

The panel noted the intra-service time appeared too low to perform 11-12 studies and calculated the existing average nerve study intra-service time of 6.70 minutes times 11.5 studies to come up with 77.05 minutes.

The expert panel identified existing code 99345 at 4.09 RVU and 75 minutes intra-service time as a crosswalk. The panel recommends an RVU of 4.10 and times of 15/77/15.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 183032
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 95177 Percentage 52.00 %

Specialty AAPMR Frequency 36606 Percentage 19.99 %

Specialty ACP Frequency 14643 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 45,758 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes.

Specialty AAN Frequency 23794 Percentage 51.99 %

Specialty AAPMR Frequency 9152 Percentage 20.00 %

Specialty ACP Frequency 3661 Percentage 8.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95913 Tracking Number R20 Original Specialty Recommended RVU: **4.30**
Presented Recommended RVU: **4.30**
Global Period: XXX RUC Recommended RVU: **4.20**

CPT Descriptor: 13 or more nerve conduction studies; (95900-95904 have been deleted. For nerve conduction studies, see 95907-95913)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 61-year-old diabetic man presents with symptoms of bilateral carpal tunnel syndrome, which is severe on the right where there is thenar wasting, as well as progressive numbness and tingling in the lower limbs. You are asked to evaluate for carpal tunnel syndrome vs. ulnar neuropathy as well as to rule out length-dependent peripheral neuropathy.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician or other qualified healthcare professional reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical question. The physician or other qualified healthcare professional considers the clinical presentation, the potential anatomic lesions that could cause the clinical manifestations, any anatomic or other factors that may cause technical limitations (such as body habitus, edema, prior surgery), and/or questions being posed by the referring physician. The stimulating, recording, and ground electrode placement and the test design are individualized to the patient's unique anatomy and the particular clinical question being investigated.

Description of Intra-Service Work: The stimulating electrode is placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, both proximal and distal stimulation are performed. Motor nerve conduction study recordings with or without F-wave testing, when performed, are made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings, when performed, must be made from electrodes placed directly over the specific nerve to be tested. H-reflex study recordings, when performed, must be made from electrodes placed directly over the specific nerve-muscle combination to be tested. Waveforms are reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) is adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Using well-established techniques, the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of the nerve tested are assessed. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values. Test

design changes during the course of the study in response to the information obtained. 13 or more nerve conduction studies are performed.

Description of Post-Service Work: Post-service work involves a review of the raw nerve conduction study data and the documentation of nerve conduction interpretations into a summary report prepared on site by the physician or other qualified healthcare professional.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Marianna Spanaki, MD, PhD, James Selwa, MD, MBA, Joe Zuhosky, MD, Andrea Boon, MD, John Palazzo, DSc, PT, ECS				
Specialty(s):	AAN, AANEM, AAPMR, APTA				
CPT Code:	95913				
Sample Size:	195	**Resp N:**	52	**Response:** 26.6 %	
Description of Sample:	Random surveys were sent to a group of members who indicated they perform the service				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**15.00**	50.00	360.00
Survey RVW:	0.90	3.56	**4.20**	6.68	22.28
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	30.00	45.00	**70.00**	76.00	130.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95913	**Recommended Physician Work RVU: 4.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**70.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99255	XXX	4.00	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11644	010	4.34	**RUC Time**	16,269

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13121	010	4.42	**RUC Time**	97,197

CPT Descriptor 2 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 19.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 95913**	**Key Reference CPT Code:** 99255	**Source of Time** **RUC Time**
Median Pre-Service Time	15.00	20.00	
Median Intra-Service Time	70.00	60.00	
Median Immediate Post-service Time	20.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**105.00**	**105.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.40
Urgency of medical decision making	3.90	4.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.50	4.20
Physical effort required	4.60	4.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.30
Outcome depends on the skill and judgment of physician	4.40	4.60
Estimated risk of malpractice suit with poor outcome	4.20	4.40

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.80	3.70
Intra-Service intensity/complexity	4.70	4.50
Post-Service intensity/complexity	4.00	4.50

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of representatives from the AAN, AANEM, AAPMR, and APTA reviewed the survey results. The panel estimates this code will constitute 1% of the utilization of the new nerve testing family.

The panel noted the intra-service time appeared too low to perform 13 or more studies and calculated the existing average nerve study intra-service time of 6.70 minutes times 13 studies to come up with 87.10 minutes.

The expert panel identified existing code 31636 at 4.30 RVU and 45 minutes intra-service time as a crosswalk. Code 44391 has 59 minutes of intra-service time and a 4.31 RVU.

The panel recommends an RVU of 4.30 and times of 15/87/20.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was performed previously using 95900, 95903, 95904, 95934, and 95936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAN How often? Commonly

Specialty AAPMR How often? Commonly

Specialty ACP How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 22272
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty AAN Frequency 11581 Percentage 51.99 %

Specialty AAPMR Frequency 4454 Percentage 19.99 %

Specialty ACP Frequency 1782 Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,568
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate of how current utilization of 95900, 95903, 95904, 95934, and 95936 will be divided out into the new nerve testing codes.

Specialty AAN Frequency 2895 Percentage 51.99 %

Specialty AAPMR Frequency 1114 Percentage 20.00 %

Specialty ACP Frequency 445 Percentage 7.99 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95904

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Nerve Conduction Studies**																		
13	**TAB:**	**32**																		
14						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
16	**REF**	**99212**	**Office/Outpatient Visit Established**	**14**	**0.035**			**0.48**			**16**	**2**					**10**			**4**
18	**SVY**	**95907**	1-2 nerve conduction studies	**52**	**0.037**	**0.30**	**0.53**	**1.00**	**1.96**	**4.00**	**35**	**10**			**5**	**10**	**15**	**20**	**55**	**10**
19	**REC**	**95907**	**1-2 nerve conduction studies**		**0.037**			**1.00**			**35**	**10**					**15**			**10**
20	**MPC**	**99213**	**Office/Outpatient Visit Established**		**0.053**			**0.97**			**23**	**3**					**15**			**5**
21	**MPC**	**78315**	**Bone and/or joint imaging; 3 phase study**		**0.035**			**1.02**			**18**	**5**					**8**			**5**
22																				
23						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
24	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
25	**REF**	**99213**	**Office/Outpatient Visit Established**	**15**	**0.053**			**0.97**			**23**	**3**					**15**			**5**
27	**SVY**	**95908**	3-4 nerve conduction studies	**52**	**0.056**	**0.20**	**1.00**	**1.68**	**2.54**	**5.78**	**42**	**10**			**8**	**15**	**22**	**30**	**60**	**10**
28	**REC**	**95908**	3-4 nerve conduction studies		**0.037**			**1.37**			**45**	**10**					**25**			**10**
29	***MPC***	**99382**	**Initial comprehensive preventive medicine evaluation and**		**0.055**			**1.60**			**35**	**5**					**25**			**5**
30	***MPC***	**99375**	**Physician supervision of a patient under care of home health agency (patient not present) in**		**0.037**			**1.73**			**48**	**10**					**32**			**15**
31																				
32						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**
33	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**
34	**REF**	**99214**	**Office/Outpatient Visit Established**	**14**	**0.047**			**1.50**			**40**	**5**					**25**			**10**
36	**SVY**	**95909**	5-6 nerve conduction studies	**52**	**0.060**	**0.35**	**1.50**	**2.28**	**3.53**	**9.08**	**51**	**10**			**15**	**24**	**30**	**40**	**75**	**11**
37	**REC**	**95909**	5-6 nerve conduction studies		**0.037**			**1.77**			**56**	**10**					**35**			**11**
38	**MPC**	**52000**	Cystourethroscopy (separate procedure)		**0.113**			**2.23**			**48**	**10**	**2**	**5**			**15**			**10**
39	**MPC**	**99386**	Initial comprehensive preventive medicine evaluation and management of an individual		**0.050**			**2.33**			**48**	**5**					**40**			**10**

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
40																				
41						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
42	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
43	REF	99215	Office/Outpatient Visit Established	13	0.047			2.11			55	5					35			15
45	SVY	95910	7-8 nerve conduction studies	52	0.056	0.45	2.00	2.80	4.00	12.38	65.5	13			20	29	40	50	85	12.5
46	REC	95910	7-8 nerve conduction studies		0.056			2.80			65.5	13					40			12.5
47	Crosswalk	12007	Simple repair of superficial wounds c		0.071			2.90			54	11					35			8
48	Crosswalk	99465	Delivery/birthing room resuscitation,		0.058			2.93			60	5					45			10
49	Crosswalk	75559	Cardiac magnetic resonance imaging		0.048			2.95			75	15					50			10
50	MPC	12052	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6		0.064			2.87			70	14					30			10
51	MPC	99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest		0.058			2.93			48	5					45			10

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
52																				
53						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
54	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
55	REF	99215	Office/Outpatient Visit Established	9	0.047			2.11			55	5					35			15
57	SVY	95911	9-10 nerve conduction studies	52	0.053	0.50	2.50	3.34	4.50	15.68	80	15			20	34	50	60	95	15
58	REC	95911	9-10 nerve conduction studies		0.053			3.34			80	15					50			15
59	Crosswalk	59012	Cordocentesis (intrauterine), any me		0.054			3.44			91	25					44			22
60	Crosswalk	99327	Domiciliary or rest home visit for the		0.043			3.46			100	15					60			25
61	Crosswalk	95978	Electronic analysis of implanted neu		0.055			3.50			70	5					60			5
62	MPC	11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter		0.054			3.42			93	30					30			10
63	MPC	63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord,		0.077			3.47			48						45			
64																				
65						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
66	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
67	REF	99245	Office Consultation	12	0.052			3.77			90	10					60			20
69	SVY	95912	11-12 nerve conduction studies	52	0.055	0.70	3.00	4.00	5.70	18.98	90	15			30	40	60	70	105	15
70	REC	95912	11-12 nerve conduction studies		0.055			4.00			90	15					60			15
71	Crosswalk	99345	Home visit for the evaluation and management of a new patient, which requires these 3 key		0.041			4.09			120	15					75			30
72	Crosswalk	99236	Observation or inpatient hospital care, for the evaluation and management of a patient including		0.060			4.20			94	19					55			20
73	MPC	99223	Initial Hospital Care		0.056			3.86			90	15					55			20
74	MPC	11644	Excision, malignant lesion including margins, face, ears, eyelids, nose,		0.057			4.34			108	30					45			10
75																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
76						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
77	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
78	REF	99255	Inpatient Consultation	10	0.050			4.00			105	20					60			25
80	SVY	95913	13 or more nerve conduction studies	52	0.049	0.90	3.56	4.20	6.68	22.28	105	15			30	45	70	76	130	20
81	REC	95913	13 or more nerve conduction studies		0.049			4.20			105	15					70			20
82	Crosswalk	31636	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of		0.061			4.30			115	45					45			25
83	Crosswalk	44391	Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery		0.042			4.31			141	55					59			27
84	Crosswalk	43246	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or		0.074			4.32			106	48					38			20
85	MPC	11644	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter		0.057			4.34			108	30					45			10
86	MPC	13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		0.048			4.42			117	10					60			15

ISSUE: EMG Limb

TAB: 32

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE	INTRA-TIME				IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
REF	99213	Office/Outpatient Visit Established	26	0.053			0.97			23	3			15			5
HVD	95860	Needle electromyography; 1 extremity with or without related paraspinal areas		0.028			0.96			34				34			
SVY	95860	Needle electromyography; 1 extremity with or without related paraspinal areas	93	0.040	0.35	1.00	1.25	2.00	4.00	40	10	5	15	20	30	120	10
REC	95860	Needle electromyography; 1 extremity with or without related paraspinal areas		0.026			0.96			40	10			20			10
MPC	78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological		0.044			0.96			22				22			
MPC	99213	Office or other outpatient visit for the evaluation and management of an established patient, which		0.053			0.97			23	3			15			5

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE	INTRA-TIME				IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
REF	99214	Office/Outpatient Visit Established	16	0.047			1.50			40	5			25			10
RUC	95861	2 extremities with or without related paraspinal areas		0.039			1.54			50	15			25			10
SVY	95861	2 extremities with or without related paraspinal areas	46	0.048	0.55	1.50	1.83	2.10	3.50	48.5	9.5	10	20	29	40	60	10
REC	95861	2 extremities with or without related paraspinal areas		0.038			1.54			49	10			29			10
MPC	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and		0.055			1.60			35	5			25			5
MPC	11441	Excision, other benign lesion including margins, except skin tag (unless listed		0.036			1.53			51	10			20			5

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE	INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
REF	99215	Office/Outpatient Visit Established	13	0.047			2.11			55	5			35			15
HVD	95863	3 extremities with or without related paraspinal areas		0.033			1.87			57				57			
SVY	95863	3 extremities with or without related paraspinal areas	46	0.049	0.75	1.96	2.45	2.90	4.00	61	10	10	30	40	50	75	11
REC	95863	3 extremities with or without related paraspinal areas		0.035			1.87			61	10			40			11
MPC	64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous		0.049			1.81			60	29			20			11
MPC	94002	Ventilation assist and management, initiation of pressure or volume preset		0.044			1.99			60	15			30			15

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE	INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
REF	95810	Polysomnography; sleep staging with 4 or more additional	18	0.050			2.50			66.5	15			36.5			15
HVD	95864	4 extremities with or without related paraspinal areas		0.029			1.99			68				68			
SVY	95864	4 extremities with or without related paraspinal areas	46	0.043	1.00	2.36	2.68	3.51	5.00	73.5	10	10	37	50	60	90	13.5
REC	95864	4 extremities with or without related paraspinal areas		0.029			1.99			73.5	10			50			13.5
MPC	78812	Positron emission tomography (PET) imaging; skull base to mid-thigh		0.049			1.93			50	10			30			10
MPC	11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp		0.033			2.06			76	20			30			10

SSUE: EMG Misc

TAB: 32

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	99214	Office/Outpatient Visit Established	6	0.047			1.50			40	5					25			10
RUC	95865	Needle electromyography; larynx		0.071			1.57			37.5	13					15			10
SVY	95865	Needle electromyography; larynx	26	0.079	0.45	1.05	1.55	2.00	5.00	31.5	10			3	10	15	20	30	6.5
REC	95865	Needle electromyography; larynx		0.075			1.57			35	10					15			10
MPC	77290	Therapeutic radiology simulation-aided field setting; complex		0.022			1.56			70	0					70			0
MPC	99382	Initial Preventative Visit age 1-4		0.055			1.60			35	5					25			5

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	99214	Office/Outpatient Visit Established	6	0.047			1.50			40	5					25			10
RUC	95866	Needle electromyography; hemidiaphragm		0.053			1.25			35	10					15			10
SVY	95866	Needle electromyography; hemidiaphragm	27	0.100	0.75	1.34	1.95	2.23	6.00	35	10			3	10	15	20	60	10
REC	95866	Needle electromyography; hemidiaphragm		0.053			1.25			35	10					15			10
MPC	13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for		0.050			1.24			25	0					25			0
MPC	74160	Computed tomography, abdomen; with contrast material(s)		0.073			1.27			23	3					15			5

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99214	Office/Outpatient Visit Established	6	0.047			1.50			40	5					25			10
HRVD	95867	cranial nerve supplied muscle(s), unilateral		0.034			0.79			23						23			
SVY	95867	cranial nerve supplied muscle(s), unilateral	38	0.047	0.40	0.81	1.15	1.97	4.00	35	10			5	10	15	15	40	10
REC	95867	cranial nerve supplied muscle(s), unilateral		0.023			0.79			35	10					15			10
MPC	29075	Application, cast; elbow to finger (short arm)		0.019			0.77			38	7					23			8
MPC	20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg,		0.101			0.79			21	5	1	5			5			5

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99214	Office/Outpatient Visit Established	8	0.047			1.50			40	5					25			10
HRVD	95868	cranial nerve supplied muscles, bilateral		0.034			1.18			35						35			
SVY	95868	cranial nerve supplied muscles, bilateral	38	0.053	0.71	1.20	1.50	2.25	5.00	40	10			8	16	20	30	60	10
REC	95868	cranial nerve supplied muscles, bilateral		0.037			1.18			40	10					20			10
MPC	56605	Biopsy of vulva or perineum (separate procedure); 1 lesion		0.044			1.10			35	10					15			10
MPC	99238	Hospital discharge day management; 30 minutes or less		0.044			1.28			38	8					20			10

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	99213	Office/Outpatient Visit Established	7	0.053			0.97			23	3					15			5
HRVD	95869	thoracic paraspinal muscles (excluding T1 or T12)		0.016			0.37			23						23			
SVY	95869	thoracic paraspinal muscles (excluding T1 or T12)	42	0.047	0.25	0.50	1.16	1.71	5.00	35	10			3	10	15	19	50	10
REC	95869	thoracic paraspinal muscles (excluding T1 or T12)		-0.005			0.37			35	10					15			10
MPC	36405	Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for		0.013			0.31			18	4					10			4
MPC	92250	Fundus photography with interpretation and report		0.036			0.44			14	0					9			5

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	99213	Office/Outpatient Visit Established	11	0.053			0.97			23	3					15			5
CMS/ Other	95870	limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters		0.012			0.37			30						30			
SVY	95870	limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral),	43	0.037	0.40	0.53	1.00	1.85	3.00	35	10			5	10	15	20	60	10
REC	95870	limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal		-0.005			0.37			35	10					15			10
MPC	36405	Venipuncture, younger than age 3 years, necessitating physician's		0.013			0.31			18	4					10			4
MPC	92250	Fundus photography with interpretation and report		0.036			0.44			14	0					9			5

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; 1 extremity with or without related paraspinal areas

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95860.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Needle electromyography; 2 extremities with or without related paraspinal areas

(For dynamic electromyography performed during motion analysis studies, see 96002-96003)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95861.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; 3 extremities with or without related paraspinal areas

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95863.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Needle electromyography; 4 extremities with or without related paraspinal areas

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95864.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; larynx

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95865.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; hemidiaphragm

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95866.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; cranial nerve supplied muscle(s), unilateral

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95867.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

CPT Code: 95868
Specialty Society('s) AAN, AANEM, AAPMR, APTA

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; cranial nerve supplied muscles, bilateral

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95868.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing CPT code 95869.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the EMG codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The reference code is the existing code 95870.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
1-2 nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

3-4 nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

Post-Service Clinical Labor Activities:

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

5-6 nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

7-8 nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

9-10 nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information)

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

11-12 nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical informatio

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

13 or more nerve conduction studies

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians and health care providers to develop recommended inputs by phone and email. The members of the panel represent a variety of geographic locations and practice settings. The panel reviewed the existing RUC-approved inputs for the Nerve Testing codes and modified based on those.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The new codes describe nerve testing that was previously reported using 95900-04.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.

The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers.

Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	REVISED		AMA Specialty Society Recommendation	REFERENCE CODE		REFERENCE CODE		REFERENCE CODE					
2				95900		95903		95904		95907		95908	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study		Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study		Nerve conduction, amplitude and latency/velocity study, each nerve; sensory		1-2 nerve conduction studies		3-4 nerve conduction studies	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**24.0**	**0.0**	**30.0**	**0.0**	**24.0**	**0.0**	**27.0**	**0.0**	**34.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**24.0**	**0.0**	**30.0**	**0.0**	**24.0**	**0.0**	**27.0**	**0.0**	**34.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms												
13	Coordinate pre-surgery services												
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnostic Technologist							**3**		**3**	
22	Obtain vital signs												
23	Provide pre-service education/obtain consent	L037A	Electrodiagnostic Technologist							**2**		**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnostic Technologist							**2**		**2**	
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnostic Technologist							**2**		**2**	
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure	L037A	Electrodiagnostic Technologist							**15**		**22**	
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains												
32	Clean room/equipment by physician staff	L037A	Electrodiagnostic Technologist							**3**		**3**	
33	Clean Scope												
34	Clean Surgical Instrument Package												
35	Complete diagnostic forms, lab & X-ray requisitions												
36	Review/read X-ray, lab, and pathology reports												
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
43	**POST-SERVICE Period**												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions												
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16										
48	99212 27 minutes		27										
49	99213 36 minutes		36										
50	99214 53 minutes		53										
51	99215 63 minutes		63										
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*												
54	**End: with last office visit before end of global period**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack										
57	electrode skin prep gel (NuPrep)	SJ022	ml	**100**		**100**		**100**		**100**		**100**	
58	sensor strip, skin temperature	SJ045	item	**1**		**1**		**1**		**1**		**1**	
59	gown, patient	SB026	item	**1**		**1**		**1**		**1**		**1**	
60	electrode, ground	SD059	item	**1**		**1**		**1**		**0**		**0**	
61	gauze, sterile 4in x 4in	SG055	item	**2**		**2**		**2**		**4**		**8**	
62	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**		**1**	
63	gloves, non-sterile	SB022	pair	**2**		**2**		**1**		**2**		**2**	
64	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**		**7**	
65	electrode conductive gel	SJ020	ml	**5**		**5**		**5**		**0**		**0**	
66	paper, recording (per sheet)	SK059	item	**1**		**1**				**1**		**1**	
67	measuring tape, paper	SK048	item	**1**		**1**		**1**		**1**		**1**	
68	swab-pad, alcohol	SJ053	item	**2**		**2**		**2**		**4**		**8**	
69	tape, surgical paper 1in (Micropore)	SG079	inch	**6**		**6**		**6**		**12**		**24**	
70	povidone soln (Betadine)	SJ041	ml	**1**		**10**		**1**		**0**		**0**	
71	electrode, bar-style (single)	SD052	item			**1**				**0**		**0**	
72	Disposable electrode pack*									**1**		**1**	
73	**EQUIPMENT**	**CODE**											
74	EMG-NCV-EP system, 8 channel	EQ024		**24**	**0**	**30**	**0**	**24**	**0**	**27**		**34**	
75	table, exam	EF023		**24**	**0**	**30**	**0**	**24**	**0**	**27**		**34**	
76	hydrocollator, hot	EQ130		**24**	**0**			**24**	**0**	**27**		**34**	
77													
78	*invoice provided for new supply item												

	A	B	C	N	O	P	Q	R	S	T	U	V	W
1	REVISED												
2				**95909**		**95910**		**95911**		**95912**		**95913**	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	5-6 nerve conduction studies		7-8 nerve conduction studies		9-10 nerve conduction studies		11-12 nerve conduction studies		13 or more nerve conduction studies	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**42.0**	**0.0**	**62.0**	**0.0**	**76.0**	**0.0**	**89.0**	**0.0**	**99.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**42.0**	**0.0**	**62.0**	**0.0**	**76.0**	**0.0**	**89.0**	**0.0**	**99.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms												
13	Coordinate pre-surgery services												
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnost	**3**		**3**		**3**		**3**		**3**	
22	Obtain vital signs												
23	Provide pre-service education/obtain consent	L037A	Electrodiagnost	**2**		**2**		**2**		**2**		**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnost	**2**		**2**		**2**		**2**		**2**	
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnost	**2**		**2**		**2**		**2**		**2**	
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure	L037A	Electrodiagnost	**30**		**50**		**64**		**77**		**87**	
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains												
32	Clean room/equipment by physician staff	L037A	Electrodiagnost	**3**		**3**		**3**		**3**		**3**	
33	Clean Scope												
34	Clean Surgical Instrument Package												
35	Complete diagnostic forms, lab & X-ray requisitions												
36	Review/read X-ray, lab, and pathology reports												
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
43	**POST-SERVICE Period**												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions												
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16										
48	99212 27 minutes		27										
49	99213 36 minutes		36										
50	99214 53 minutes		53										
51	99215 63 minutes		63										
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*												
54	**End: with last office visit before end of global period**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack										
57	electrode skin prep gel (NuPrep)	SJ022	ml	**100**		**100**		**100**		**100**		**100**	
58	sensor strip, skin temperature	SJ045	item	**1**		**1**		**1**		**1**		**1**	
59	gown, patient	SB026	item	**1**		**1**		**1**		**1**		**1**	
60	electrode, ground	SD059	item	**0**		**0**		**0**		**0**		**0**	
61	gauze, sterile 4in x 4in	SG055	item	**12**		**16**		**20**		**24**		**26**	
62	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**		**1**	
63	gloves, non-sterile	SB022	pair	**2**		**2**		**2**		**2**		**2**	
64	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**		**7**	
65	electrode conductive gel	SJ020	ml	**0**		**0**		**0**		**0**		**0**	
66	paper, recording (per sheet)	SK059	item	**1**		**1**		**2**		**2**		**2**	
67	measuring tape, paper	SK048	item	**1**		**1**		**1**		**1**		**1**	
68	swab-pad, alcohol	SJ053	item	**12**		**16**		**20**		**24**		**26**	
69	tape, surgical paper 1in (Micropore)	SG079	inch	**36**		**48**		**60**		**72**		**78**	
70	povidone soln (Betadine)	SJ041	ml	**0**		**0**		**0**		**0**		**0**	
71	electrode, bar-style (single)	SD052	item	**0**		**0**		**0**		**0**		**0**	
72	Disposable electrode pack*			**1**		**2**		**2**		**2**		**2**	
73	**EQUIPMENT**	**CODE**											
74	EMG-NCV-EP system, 8 channel	EQ024		**42**		**52**		**62**		**72**		**82**	
75	table, exam	EF023		**42**		**52**		**62**		**72**		**82**	
76	hydrocollator, hot	EQ130		**42**		**52**		**62**		**72**		**82**	
77													
78	*invoice provided for new supply item												

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95860		95860		95861		95861	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**30.0**	**0.0**	**32.0**	**0.0**	**40.0**	**0.0**	**41.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**30.0**	**0.0**	**32.0**	**0.0**	**24.0**	**0.0**	**41.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity - *specify:*										
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnostic Technologist			**3**				**3**	
22	Obtain vital signs										
23	Provide pre-service education/obtain consent	L037A	Electrodiagnostic Technologist			**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnostic Technologist			**2**				**2**	
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnostic Technologist			**2**				**2**	
27	Sedate/apply anesthesia										
28	**Intra-service**										
29	Assist physician in performing procedure	L037A	Electrodiagnostic Technologist			**20**				**29**	
30	**Post-Service**										
31	Monitor pt. following service/check tubes, monitors, drains										
32	Clean room/equipment by physician staff	L037A	Electrodiagnostic Technologist			**3**				**3**	
33	Clean Scope										
34	Clean Surgical Instrument Package										
35	Complete diagnostic forms, lab & X-ray requisitions										
36	Review/read X-ray, lab, and pathology reports										
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
38	Other Clinical Activity - *specify:*										
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions										
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
56	pack, minimum multi-specialty visit	SA048	pack								
57	electrode needle, monopolar EMG w-lead	SD051	item	**1**				**0**			
58	electrode needle, concentric EMG w-lead	SD049	item	**0**		**1**		**1**		**1**	
59	electrode, ground	SD059	item	**1**		**0**		**1**		**0**	
60	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**	

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95860		95860		95861		95861	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
61	gloves, non-sterile	SB022	pair	**2**		**2**		**2**		**2**	
62	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**	
63	gown, patient	SB026	item	**1**		**1**		**1**		**1**	
64	paper, recording (per sheet)	SK059	item	**3**		**3**		**5**		**5**	
65	electrode conductive gel	SJ020	ml	**5**		**0**		**5**		**0**	
66	swab-pad, alcohol	SJ053	item	**2**		**6**		**4**		**12**	
67	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**6**		**3**		**6**		**6**	
68	gauze, sterile 4in x 4in	SG055	item	**2**		**2**		**4**		**4**	
69	tape, surgical paper 1in (Micropore)	SG079	inch	**6**		**6**		**6**		**6**	
70	Disposable electrode pack*					**1**				**2**	
71	**EQUIPMENT**	**CODE**									
72	EMG-NCV-EP system, 8 channel	EQ024		**24**	**0**	**32**		**24**	**0**	**44**	
73	table, exam	EF023		**24**	**0**	**32**		**24**	**0**	**44**	
74	hydrocollator, hot	EQ130		**24**	**0**	**0**					
75											
76	*invoice provided for new supply item										

	A	B	C	L	M	N	O	P	Q	R	S
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95863		95863		95864		95864	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG;4 extremities with or without related paraspinal areas			
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**50.0**	**0.0**	**52.0**	**0.0**	**60.0**	**0.0**	**62.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**34.0**	**0.0**	**52.0**	**0.0**	**44.0**	**0.0**	**62.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity - *specify:*										
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnost			**3**				**3**	
22	Obtain vital signs										
23	Provide pre-service education/obtain consent	L037A	Electrodiagnost			**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnost			**2**				**2**	
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnost			**2**				**2**	
27	Sedate/apply anesthesia										
28	**Intra-service**										
29	Assist physician in performing procedure	L037A	Electrodiagnost			**40**				**50**	
30	**Post-Service**										
31	Monitor pt. following service/check tubes, monitors, drains										
32	Clean room/equipment by physician staff	L037A	Electrodiagnost			**3**				**3**	
33	Clean Scope										
34	Clean Surgical Instrument Package										
35	Complete diagnostic forms, lab & X-ray requisitions										
36	Review/read X-ray, lab, and pathology reports										
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
38	Other Clinical Activity - *specify:*										
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions										
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
56	pack, minimum multi-specialty visit	SA048	pack								
57	electrode needle, monopolar EMG w-lead	SD051	item	**0**				**0**			
58	electrode needle, concentric EMG w-lead	SD049	item	**1**		**1**		**1**		**1**	
59	electrode, ground	SD059	item	**1**		**0**		**1**		**0**	
60	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**	

	A	B	C	L	M	N	O	P	Q	R	S
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95863		95863		95864		95864	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG;4 extremities with or without related paraspinal areas			
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
61	gloves, non-sterile	SB022	pair	**2**		**2**		**2**		**2**	
62	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**	
63	gown, patient	SB026	item	**1**		**1**		**1**		**1**	
64	paper, recording (per sheet)	SK059	item	**5**		**7**				**9**	
65	electrode conductive gel	SJ020	ml	**5**		**0**		**5**		**0**	
66	swab-pad, alcohol	SJ053	item	**4**		**18**		**4**		**24**	
67	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**9**		**9**		**12**		**12**	
68	gauze, sterile 4in x 4in	SG055	item	**6**		**6**		**6**		**8**	
69	tape, surgical paper 1in (Micropore)	SG079	inch	**6**		**6**		**6**		**6**	
70	Disposable electrode pack*					**3**				**4**	
71	**EQUIPMENT**	**CODE**									
72	EMG-NCV-EP system, 8 channel	EQ024		**34**	**0**	**58**		**44**	**0**	**71**	
73	table, exam	EF023		**34**	**0**	**58**		**44**	**0**	**71**	
74	hydrocollator, hot	EQ130									
75											
76	*invoice provided for new supply item										

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95865		95865		95866		95866		95867		95867	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; larynx		Needle electromyography; larynx		Needle electromyography; hemidiaphragm		Needle electromyography; hemidiaphragm		Needle electromyography; cranial nerve supplied muscle(s), unilateral		Needle electromyography; cranial nerve supplied muscle(s), unilateral	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnos	**26.0**	**0.0**	**27.0**	**0.0**	**26.0**	**0.0**	**27.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**23.0**	**0.0**	**27.0**	**0.0**	**23.0**	**0.0**	**27.0**	**0.0**	**14.0**	**0.0**	**27.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms														
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent														
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - *specify:*														
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnos			**3**				**3**				**3**	
22	Obtain vital signs														
23	Provide pre-service education/obtain consent	L037A	Electrodiagnos			**2**				**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnos			**2**				**2**				**2**	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnos			**2**				**2**				**2**	
27	Sedate/apply anesthesia														
28	**Intra-service**														
29	Assist physician in performing procedure														
30	**Post-Service**	L037A	Electrodiagnos			**15**				**15**				**15**	
31	Monitor pt. following service/check tubes, monitors, drains														
32	Clean room/equipment by physician staff	L037A	Electrodiagnos			**3**				**3**				**3**	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions														
36	Review/read X-ray, lab, and pathology reports														
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions														
38	Other Clinical Activity - *specify:*														
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
45	Conduct phone calls/call in prescriptions														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95865		95865		95866		95866		95867		95867	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; larynx		Needle electromyography; larynx		Needle electromyography; hemidiaphragm		Needle electromyography; hemidiaphragm		Needle electromyography; cranial nerve supplied muscle(s), unilateral		Needle electromyography; cranial nerve supplied muscle(s), unilateral	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack	**1**		**1**		**1**		**1**				**1**	
57	electrode needle, concentric EMG w-lead	SD049	item	**1**		**1**		**1**		**1**		**1**		**1**	
58	electrode, ground	SD059	item	**1**		**0**		**1**		**0**		**1**		**0**	
59	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**		**1**		**1**	
60	gloves, non-sterile	SB022	pair									**2**		**0**	
61	paper, exam table	SB036	foot									**7**		**0**	
62	gown, patient	SB026	item									**1**		**0**	
63	paper, recording (per sheet)	SK059	item	**5**		**5**		**5**		**5**		**3**		**3**	
64	electrode conductive gel	SJ020	ml	**1**		**0**		**1**		**0**		**5**		**0**	
65	swab-pad, alcohol	SJ053	item	**4**		**4**		**4**		**4**		**4**		**4**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**6**				**6**		**6**		**6**	
67	gauze, sterile 4in x 4in	SG055	item	**4**		**4**		**4**		**4**		**4**		**4**	
68	tape, surgical paper 1in (Micropore)	SG079	inch									**6**		**0**	
69	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	**6**		**6**		**6**		**6**				**6**	
70	Disposable electrode pack*					**1**				**1**				**1**	
71	**EQUIPMENT**	**CODE**													
72	EMG-NCV-EP system, 8 channel	EQ024		**23**	**0**	**27**		**23**	**0**	**27**		**14**	**0**	**27**	
73	table, exam	EF023		**23**	**0**	**27**		**23**	**0**	**27**		**14**	**0**	**27**	
74	EMG-NCV-EP system, 2-4 channel	EQ023													
75															
76	*invoice provided for new supply item														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95868		95868		95869		95869		95870		95870	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnos	**40.0**	**0.0**	**32.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**24.0**	**0.0**	**32.0**	**0.0**	**27.0**	**0.0**	**27.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms														
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent														
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - *specify:*														
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnos			**3**				**3**				**3**	
22	Obtain vital signs														
23	Provide pre-service education/obtain consent	L037A	Electrodiagnos			**2**				**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnos			**2**				**2**				**2**	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnos			**2**				**2**				**2**	
27	Sedate/apply anesthesia														
28	**Intra-service**														
29	Assist physician in performing procedure														
30	**Post-Service**	L037A	Electrodiagnos			**20**				**15**				**15**	
31	Monitor pt. following service/check tubes, monitors, drains														
32	Clean room/equipment by physician staff	L037A	Electrodiagnos			**3**				**3**				**3**	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions														
36	Review/read X-ray, lab, and pathology reports														
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions														
38	Other Clinical Activity - *specify:*														
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
45	Conduct phone calls/call in prescriptions														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95868		95868		95869		95869		95870		95870	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack			1		1		1		1		1	
57	electrode needle, concentric EMG w-lead	SD049	item	1		1		1		1		1		1	
58	electrode, ground	SD059	item	1		0		1		0		1		0	
59	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1		1		1		1	
60	gloves, non-sterile	SB022	pair	2		0									
61	paper, exam table	SB036	foot	7		0									
62	gown, patient	SB026	item	1		0									
63	paper, recording (per sheet)	SK059	item	3		5		5		5		5		5	
64	electrode conductive gel	SJ020	ml	5		0		1		0		1		0	
65	swab-pad, alcohol	SJ053	item	4		8		4		4		4		4	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	6		6				6				6	
67	gauze, sterile 4in x 4in	SG055	item	4		8		4		4		4		4	
68	tape, surgical paper 1in (Micropore)	SG079	inch	4		0									
69	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch			6		6		6		6		6	
70	Disposable electrode pack*					1				1				1	
71	**EQUIPMENT**	**CODE**													
72	EMG-NCV-EP system, 8 channel	EQ024		24	0	35						14	0	27	
73	table, exam	EF023		24	0	35		27	0	27		14	0	27	
74	EMG-NCV-EP system, 2-4 channel	EQ023						27	0	27					
75															
76	*invoice provided for new supply item														

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	REVISED		AMA Specialty Society Recommendation	REFERENCE CODE		REFERENCE CODE		REFERENCE CODE					
2				95900		95903		95904		95907		95908	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study		Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study		Nerve conduction, amplitude and latency/velocity study, each nerve; sensory		1-2 nerve conduction studies		3-4 nerve conduction studies	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**24.0**	**0.0**	**30.0**	**0.0**	**24.0**	**0.0**	**27.0**	**0.0**	**34.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**24.0**	**0.0**	**30.0**	**0.0**	**24.0**	**0.0**	**27.0**	**0.0**	**34.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms												
13	Coordinate pre-surgery services												
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnostic Technologist							**3**		**3**	
22	Obtain vital signs												
23	Provide pre-service education/obtain consent	L037A	Electrodiagnostic Technologist							**2**		**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnostic Technologist							**2**		**2**	
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnostic Technologist							**2**		**2**	
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure	L037A	Electrodiagnostic Technologist							**15**		**22**	
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains												
32	Clean room/equipment by physician staff	L037A	Electrodiagnostic Technologist							**3**		**3**	
33	Clean Scope												
34	Clean Surgical Instrument Package												
35	Complete diagnostic forms, lab & X-ray requisitions												
36	Review/read X-ray, lab, and pathology reports												
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
43	**POST-SERVICE Period**												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions												
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16										
48	99212 27 minutes		27										
49	99213 36 minutes		36										
50	99214 53 minutes		53										
51	99215 63 minutes		63										
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*												
54	**End: with last office visit before end of global period**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack										
57	electrode skin prep gel (NuPrep)	SJ022	ml	**100**		**100**		**100**		**0**		**0**	
58	sensor strip, skin temperature	SJ045	item	**1**		**1**		**1**		**1**		**1**	
59	gown, patient	SB026	item	**1**		**1**		**1**		**1**		**1**	
60	electrode, ground	SD059	item	**1**		**1**		**1**		**0**		**0**	
61	gauze, sterile 4in x 4in	SG055	item	**2**		**2**		**2**		**0**		**0**	
62	gauze, non-sterile 4in x 4in	SG051								**4**		**8**	
63	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**		**1**	
64	gloves, non-sterile	SB022	pair	**2**		**2**		**1**		**2**		**2**	
65	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**		**7**	
66	electrode conductive gel	SJ020	ml	**5**		**5**		**5**		**0**		**0**	
67	paper, recording (per sheet)	SK059	item	**1**		**1**				**1**		**1**	
68	measuring tape, paper	SK048	item	**1**		**1**		**1**		**1**		**1**	
69	swab-pad, alcohol	SJ053	item	**2**		**2**		**2**		**4**		**8**	
70	tape, surgical paper 1in (Micropore)	SG079	inch	**6**		**6**		**6**		**0**		**0**	
71	povidone soln (Betadine)	SJ041	ml	**1**		**10**		**1**		**0**		**0**	
72	electrode, bar-style (single)	SD052	item			**1**				**0**		**0**	
73	Disposable electrode pack*	SD275								**1**		**1**	
74	**EQUIPMENT**	**CODE**											
75	EMG-NCV-EP system, 8 channel	EQ024		**24**	**0**	**30**	**0**	**24**	**0**	**27**		**34**	
76	table, exam	EF023		**24**	**0**	**30**	**0**	**24**	**0**	**27**		**34**	
77	hydrocollator, hot	EQ130		**24**	**0**			**24**	**0**	**27**		**34**	
78													
79	*invoice provided for new supply item												

	A	B	C	N	O	P	Q	R	S	T	U	V	W
1	REVISED												
2				**95909**		**95910**		**95911**		**95912**		**95913**	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	5-6 nerve conduction studies		7-8 nerve conduction studies		9-10 nerve conduction studies		11-12 nerve conduction studies		13 or more nerve conduction studies	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**42.0**	**0.0**	**52.0**	**0.0**	**62.0**	**0.0**	**72.0**	**0.0**	**82.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**42.0**	**0.0**	**52.0**	**0.0**	**62.0**	**0.0**	**72.0**	**0.0**	**82.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms												
13	Coordinate pre-surgery services												
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnost	**3**		**3**		**3**		**3**		**3**	
22	Obtain vital signs												
23	Provide pre-service education/obtain consent	L037A	Electrodiagnost	**2**		**2**		**2**		**2**		**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnost	**2**		**2**		**2**		**2**		**2**	
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnost	**2**		**2**		**2**		**2**		**2**	
27	Sedate/apply anesthesia												
28	**Intra-service**											**0**	
29	Assist physician in performing procedure	L037A	Electrodiagnost	**30**		**40**		**50**		**60**		**70**	
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains												
32	Clean room/equipment by physician staff	L037A	Electrodiagnost	**3**		**3**		**3**		**3**		**3**	
33	Clean Scope												
34	Clean Surgical Instrument Package												
35	Complete diagnostic forms, lab & X-ray requisitions												
36	Review/read X-ray, lab, and pathology reports												
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
43	**POST-SERVICE Period**												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions												
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16										
48	99212 27 minutes		27										
49	99213 36 minutes		36										
50	99214 53 minutes		53										
51	99215 63 minutes		63										
52	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
53	Other Clinical Activity - *specify:*												
54	**End: with last office visit before end of global period**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack										
57	electrode skin prep gel (NuPrep)	SJ022	ml	**0**		**0**		**0**		**0**		**0**	
58	sensor strip, skin temperature	SJ045	item	**1**		**1**		**1**		**1**		**1**	
59	gown, patient	SB026	item	**1**		**1**		**1**		**1**		**1**	
60	electrode, ground	SD059	item	**0**		**0**		**0**		**0**		**0**	
61	gauze, sterile 4in x 4in	SG055	item	**0**		**0**		**0**		**0**		**0**	
62	gauze, non-sterile 4in x 4in	SG051		**12**		**16**		**20**		**24**		**26**	
63	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**		**1**	
64	gloves, non-sterile	SB022	pair	**2**		**2**		**2**		**2**		**2**	
65	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**		**7**	
66	electrode conductive gel	SJ020	ml	**0**		**0**		**0**		**0**		**0**	
67	paper, recording (per sheet)	SK059	item	**1**		**1**		**2**		**2**		**2**	
68	measuring tape, paper	SK048	item	**1**		**1**		**1**		**1**		**1**	
69	swab-pad, alcohol	SJ053	item	**12**		**16**		**20**		**24**		**26**	
70	tape, surgical paper 1in (Micropore)	SG079	inch	**0**		**0**		**0**		**0**		**0**	
71	povidone soln (Betadine)	SJ041	ml	**0**		**0**		**0**		**0**		**0**	
72	electrode, bar-style (single)	SD052	item	**0**		**0**		**0**		**0**		**0**	
73	Disposable electrode pack*	SD275		**1**		**2**		**2**		**2**		**2**	
74	**EQUIPMENT**	**CODE**											
75	EMG-NCV-EP system, 8 channel	EQ024		**42**		**52**		**62**		**72**		**82**	
76	table, exam	EF023		**42**		**52**		**62**		**72**		**82**	
77	hydrocollator, hot	EQ130		**42**		**52**		**62**		**72**		**82**	
78													
79	*invoice provided for new supply item												

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95860		95860		95861		95861	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**30.0**	**0.0**	**32.0**	**0.0**	**40.0**	**0.0**	**41.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**30.0**	**0.0**	**32.0**	**0.0**	**24.0**	**0.0**	**41.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity - *specify:*										
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnostic Technologist			**3**				**3**	
22	Obtain vital signs										
23	Provide pre-service education/obtain consent	L037A	Electrodiagnostic Technologist			**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnostic Technologist			**2**				**2**	
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnostic Technologist			**2**				**2**	
27	Sedate/apply anesthesia										
28	**Intra-service**										
29	Assist physician in performing procedure	L037A	Electrodiagnostic Technologist			**20**				**29**	
30	**Post-Service**										
31	Monitor pt. following service/check tubes, monitors, drains										
32	Clean room/equipment by physician staff	L037A	Electrodiagnostic Technologist			**3**				**3**	
33	Clean Scope										
34	Clean Surgical Instrument Package										
35	Complete diagnostic forms, lab & X-ray requisitions										
36	Review/read X-ray, lab, and pathology reports										
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
38	Other Clinical Activity - *specify:*										
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions										
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
56	pack, minimum multi-specialty visit	SA048	pack								
57	electrode needle, monopolar EMG w-lead	SD051	item	**1**				**0**			
58	electrode needle, concentric EMG w-lead	SD049	item	**0**		**1**		**1**		**1**	
59	electrode, ground	SD059	item	**1**		**0**		**1**		**0**	
60	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**	

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95860		95860		95861		95861	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 1 extremity with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas		Needle EMG; 2 extremities with or without related paraspinal areas	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
61	gloves, non-sterile	SB022	pair	**2**		**2**		**2**		**2**	
62	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**	
63	gown, patient	SB026	item	**1**		**1**		**1**		**1**	
64	paper, recording (per sheet)	SK059	item	**3**		**3**		**5**		**5**	
65	electrode conductive gel	SJ020	ml	**5**		**0**		**5**		**0**	
66	swab-pad, alcohol	SJ053	item	**2**		**6**		**4**		**12**	
67	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**6**		**3**		**6**		**6**	
68	gauze, sterile 4in x 4in	SG055	item	**2**		**2**		**4**		**4**	
69	tape, surgical paper 1in (Micropore)	SG079	inch	**6**		**6**		**6**		**6**	
70	Disposable electrode pack*					**1**				**2**	
71	**EQUIPMENT**	**CODE**									
72	EMG-NCV-EP system, 8 channel	EQ024		**24**	**0**	**32**		**24**	**0**	**41**	
73	table, exam	EF023		**24**	**0**	**32**		**24**	**0**	**41**	
74	hydrocollator, hot	EQ130		**24**	**0**	**0**					
75											
76	*invoice provided for new supply item										

	A	B	C	L	M	N	O	P	Q	R	S
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95863		95863		95864		95864	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG;4 extremities with or without related paraspinal areas			
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnost	**50.0**	**0.0**	**52.0**	**0.0**	**60.0**	**0.0**	**71.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**34.0**	**0.0**	**52.0**	**0.0**	**44.0**	**0.0**	**62.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**9.0**	**0.0**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity - *specify:*										
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnost			**3**				**3**	
22	Obtain vital signs										
23	Provide pre-service education/obtain consent	L037A	Electrodiagnost			**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnost			**2**				**2**	
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnost			**2**				**2**	
27	Sedate/apply anesthesia										
28	**Intra-service**										
29	Assist physician in performing procedure	L037A	Electrodiagnost			**40**				**50**	
30	**Post-Service**										
31	Monitor pt. following service/check tubes, monitors, drains										
32	Clean room/equipment by physician staff	L037A	Electrodiagnost			**3**				**3**	
33	Clean Scope										
34	Clean Surgical Instrument Package										
35	Complete diagnostic forms, lab & X-ray requisitions										
36	Review/read X-ray, lab, and pathology reports										
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
38	Other Clinical Activity - *specify:*										
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions										
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
56	pack, minimum multi-specialty visit	SA048	pack								
57	electrode needle, monopolar EMG w-lead	SD051	item	**0**				**0**			
58	electrode needle, concentric EMG w-lead	SD049	item	**1**		**1**		**1**		**1**	
59	electrode, ground	SD059	item	**1**		**0**		**1**		**0**	
60	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**	

	A	B	C	L	M	N	O	P	Q	R	S
1	REVISED			REFERENCE CODE				REFERENCE CODE			
2				95863		95863		95864		95864	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG; 3 extremities with or without related paraspinal areas		Needle EMG;4 extremities with or without related paraspinal areas			
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
61	gloves, non-sterile	SB022	pair	**2**		**2**		**2**		**2**	
62	paper, exam table	SB036	foot	**7**		**7**		**7**		**7**	
63	gown, patient	SB026	item	**1**		**1**		**1**		**1**	
64	paper, recording (per sheet)	SK059	item	**5**		**7**				**9**	
65	electrode conductive gel	SJ020	ml	**5**		**0**		**5**		**0**	
66	swab-pad, alcohol	SJ053	item	**4**		**18**		**4**		**24**	
67	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**9**		**9**		**12**		**12**	
68	gauze, sterile 4in x 4in	SG055	item	**6**		**6**		**6**		**8**	
69	tape, surgical paper 1in (Micropore)	SG079	inch	**6**		**6**		**6**		**6**	
70	Disposable electrode pack*					**3**				**4**	
71	**EQUIPMENT**	**CODE**									
72	EMG-NCV-EP system, 8 channel	EQ024		**34**	**0**	**52**		**44**	**0**	**62**	
73	table, exam	EF023		**34**	**0**	**52**		**44**	**0**	**62**	
74	hydrocollator, hot	EQ130									
75											
76	*invoice provided for new supply item										

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95865		95865		95866		95866		95867		95867	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; larynx		Needle electromyography; larynx		Needle electromyography; hemidiaphragm		Needle electromyography; hemidiaphragm		Needle electromyography; cranial nerve supplied muscle(s), unilateral		Needle electromyography; cranial nerve supplied muscle(s), unilateral	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnos	**26.0**	**0.0**	**27.0**	**0.0**	**26.0**	**0.0**	**27.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**23.0**	**0.0**	**27.0**	**0.0**	**23.0**	**0.0**	**27.0**	**0.0**	**14.0**	**0.0**	**27.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**8.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms														
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent														
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - *specify:*														
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnos			**3**				**3**				**3**	
22	Obtain vital signs														
23	Provide pre-service education/obtain consent	L037A	Electrodiagnos			**2**				**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnos			**2**				**2**				**2**	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnos			**2**				**2**				**2**	
27	Sedate/apply anesthesia														
28	**Intra-service**														
29	Assist physician in performing procedure														
30	**Post-Service**	L037A	Electrodiagnos			**15**				**15**				**15**	
31	Monitor pt. following service/check tubes, monitors, drains														
32	Clean room/equipment by physician staff	L037A	Electrodiagnos			**3**				**3**				**3**	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions														
36	Review/read X-ray, lab, and pathology reports														
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions														
38	Other Clinical Activity - *specify:*														
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
45	Conduct phone calls/call in prescriptions														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95865		95865		95866		95866		95867		95867	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; larynx		Needle electromyography; larynx		Needle electromyography; hemidiaphragm		Needle electromyography; hemidiaphragm		Needle electromyography; cranial nerve supplied muscle(s), unilateral		Needle electromyography; cranial nerve supplied muscle(s), unilateral	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack	**1**		**1**		**1**		**1**				**1**	
57	electrode needle, concentric EMG w-lead	SD049	item	**1**		**1**		**1**		**1**		**1**		**1**	
58	electrode, ground	SD059	item	**1**		**0**		**1**		**0**		**1**		**0**	
59	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**		**1**		**1**		**1**		**1**		**1**	
60	gloves, non-sterile	SB022	pair									**2**		**0**	
61	paper, exam table	SB036	foot									**7**		**0**	
62	gown, patient	SB026	item									**1**		**0**	
63	paper, recording (per sheet)	SK059	item	**5**		**5**		**5**		**5**		**3**		**3**	
64	electrode conductive gel	SJ020	ml	**1**		**0**		**1**		**0**		**5**		**0**	
65	swab-pad, alcohol	SJ053	item	**4**		**4**		**4**		**4**		**4**		**4**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**6**				**6**		**6**		**6**	
67	gauze, sterile 4in x 4in	SG055	item	**4**		**4**		**4**		**4**		**4**		**4**	
68	tape, surgical paper 1in (Micropore)	SG079	inch									**6**		**0**	
69	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	**6**		**6**		**6**		**6**				**6**	
70	Disposable electrode pack*					**1**				**1**				**1**	
71	**EQUIPMENT**	**CODE**													
72	EMG-NCV-EP system, 8 channel	EQ024		**23**	**0**	**27**		**23**	**0**	**27**		**14**	**0**	**27**	
73	table, exam	EF023		**23**	**0**	**27**		**23**	**0**	**27**		**14**	**0**	**27**	
74	EMG-NCV-EP system, 2-4 channel	EQ023													
75															
76	*invoice provided for new supply item														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95868		95868		95869		95869		95870		95870	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L037A	Electrodiagnos	**40.0**	**0.0**	**32.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**24.0**	**0.0**	**32.0**	**0.0**	**27.0**	**0.0**	**27.0**	**0.0**	**30.0**	**0.0**	**27.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms														
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent														
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - *specify:*														
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037A	Electrodiagnos			**3**				**3**				**3**	
22	Obtain vital signs														
23	Provide pre-service education/obtain consent	L037A	Electrodiagnos			**2**				**2**				**2**	
24	Prepare room, equipment, supplies	L037A	Electrodiagnos			**2**				**2**				**2**	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV	L037A	Electrodiagnos			**2**				**2**				**2**	
27	Sedate/apply anesthesia														
28	**Intra-service**														
29	Assist physician in performing procedure														
30	**Post-Service**	L037A	Electrodiagnos			**20**				**15**				**15**	
31	Monitor pt. following service/check tubes, monitors, drains														
32	Clean room/equipment by physician staff	L037A	Electrodiagnos			**3**				**3**				**3**	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions														
36	Review/read X-ray, lab, and pathology reports														
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions														
38	Other Clinical Activity - *specify:*														
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														
45	Conduct phone calls/call in prescriptions														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				95868		95868		95869		95869		95870		95870	
3	**Meeting Date: April 2012** **Tab: 32** **Specialty: AAN, AANEM, AAPMR, APTA**	**CMS Code**	**Staff Type**	Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; cranial nerve supplied muscles, bilateral		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack			1		1		1		1		1	
57	electrode needle, concentric EMG w-lead	SD049	item	1		1		1		1		1		1	
58	electrode, ground	SD059	item	1		0		1		0		1		0	
59	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1		1		1		1	
60	gloves, non-sterile	SB022	pair	2		0									
61	paper, exam table	SB036	foot	7		0									
62	gown, patient	SB026	item	1		0									
63	paper, recording (per sheet)	SK059	item	3		5		5		5		5		5	
64	electrode conductive gel	SJ020	ml	5		0		1		0		1		0	
65	swab-pad, alcohol	SJ053	item	4		8		4		4		4		4	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	6		6				6				6	
67	gauze, sterile 4in x 4in	SG055	item	4		8		4		4		4		4	
68	tape, surgical paper 1in (Micropore)	SG079	inch	4		0									
69	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch			6		6		6		6		6	
70	Disposable electrode pack*					1				1				1	
71	**EQUIPMENT**	**CODE**													
72	EMG-NCV-EP system, 8 channel	EQ024		24	0	32						14	0	27	
73	table, exam	EF023		24	0	32		27	0	27		14	0	27	
74	EMG-NCV-EP system, 2-4 channel	EQ023						27	0	27					
75															
76	*invoice provided for new supply item														

administration), 94726 (Plethysmography for determination of lung volumes and, when performed, airway resistance), 94727 (Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes), and 94728 (Airway resistance by impulse oscillometry), involve very similar work and should have the same work RVU. CPT code 94240 (Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method) (work RVU=0.26) is being deleted for CY 2012 and the utilization associated with that service is expected to be captured under new CPT codes 94726 and 92727. We believe that a work RVU of 0.26 appropriately reflects the work associated with CPT codes 94060, 94726, 94727, and 94728. We believe this value is further supported by CPT code 97012 (Application of a modality to 1 or more areas; traction, mechanical) (work RVU=0.25) which has similar time and intensity. The AMA RUC recommended a work RVU of 0.31 for CPT codes 94060, 94726, 94727, and 94728, which corresponded to each surveys 25th percentile work RVU. We are assigning a work RVU of 0.26 to CPT codes 94060, 94726, 94727, and 94728 on an interim final basis for CY 2012.

After clinical review of CPT code 94729 (Diffusing capacity (*e.g.,* carbon monoxide, membrane) (List separately in addition to code for primary procedure)), we believe that a work RVU of 0.17 accurately reflects the work associated with this service. Based on comparison to similar services, the AMA RUC recommended a work RVU of 0.19 for CPT code 94729. We believe that CPT code 94010 (Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation) (work RVU=0.17) is similar in time and intensity to CPT code 94729, and that the codes should have the same work RVU. Therefore, we are assigning a work RVU of 0.17 to CPT code 94729 on an interim final basis for CY 2012.

For the CY 2012 new, revised, and potentially misvalued CPT codes reviewed in this family of services and not specifically discussed here, we agree with the AMA RUC/HCPAC-recommended work RVUs and are setting as interim final the work RVUs listed in Table 19.

(22) Neurology and Neuromuscular Procedures: Nerve Conduction Tests (CPT Codes 95885–95887)

CPT/ HCPCS Code	Descriptor	CY 2011 Work RVU	AMA RUC/HCPAC Recommended Work RVU	CY 2012 Interim/Interim Final Work RVU	Agree/ Disagree with AMA RUC/HCPAC Recommendation	CMS Refinement to AMA RUC/HCPAC Recommended Time
95885	Musc tst done w/nerv tst lim	New	0.35	0.35	Agree	No
95886	Musc test done w/n test comp	New	0.92	0.92	Agree	No
95887	Musc tst done w/n tst nonext	New	0.73	0.73	Agree	No

CPT codes 95860, 95861, 95863 and 95864 were identified by the AMA RUC Relativity Assessment Workgroup through the Codes Reported Together 75 percent or More screen. These codes are billed commonly with CPT code 95904. The specialty societies submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. For CY 2012, the CPT Editorial Panel created 3 new add-on procedure codes: CPT codes 95885, 95886, and 95887. The CPT Editorial Panel noted, and the AMA RUC agreed, that these 3 new codes were approved with the intent that the specialties will take additional time and bring forward a more comprehensive coding solution which bundles services commonly performed together for CY 2013.

We reviewed CPT codes 95885 (Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/ velocity study; limited), 95886 (Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels), 95887 (Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/ velocity study), and are accepting the AMA RUC-recommended work RVUs and times on an interim basis, pending review of the other electromyography services for CY 2012. On an interim basis for CY 2012 we are assigning a work RVU of 0.35 to CPT code 95885, a work RVU of 0.92 to CPT code 95886, and a work RVU of 0.73 to CPT code 95887.

(23) Neurology and Neuromuscular Procedures: Autonomic Function Tests (CPT Codes 95938 and 95939)

CPT/ HCPCS Code	Descriptor	CY 2011 Work RVU	AMA RUC/HCPAC Recommended Work RVU	CY 2012 Interim/Interim Final Work RVU	Agree/ Disagree with AMA RUC/HCPAC Recommendation	CMS Refinement to AMA RUC/HCPAC Recommended Time
95938	Somatosensory testing	New	0.86	0.86	Agree	No
95939	C motor evoked upr&lwr limbs	New	2.25	2.25	Agree	No

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

EMG in Conjunction with Nerve Testing

In February 2010, CPT codes 95860, 95861, 95863 and 95864 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are billed commonly with 95904. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created three new ZZZ global codes to be reviewed at the RUC in April 2011. The CPT Editorial Panel noted, and the RUC agreed, that these three new codes were approved with the intent that the specialties will take additional time and bring forward a more comprehensive coding solution which bundles services commonly performed together during the CPT 2013 cycle.

95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited*
The RUC reviewed the survey results from 88 physicians for CPT code 95885. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed CPT code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes* (work RVU= 0.35) and agreed that the two services have comparable physician work and intensity with identical intra-service time of 15 minutes. Given this, the RUC recommends the work value for 95885 be directly crosswalked to the reference code's work RVU of 0.35. To further justify this value, the RUC reviewed another reference code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display;* complete (work RVU= 0.38) and agreed that these two analogous services have identical intra-service time, 15 minutes, and should be valued similarly. **The RUC recommends a work RVU of 0.35 for CPT code 95885.**

95886 ***Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels***
The RUC reviewed the survey results from 74 physicians for CPT code 95886. The RUC reviewed the survey's estimated work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed the reference code 95973 *Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour* (work RVU= 0.92) and agreed that the two services have similar physician work and intensity with identical intra-service time of 30 minutes. Given this, the RUC recommends the work value for 95886 be directly crosswalked to the reference code's work RVU of 0.92. To further justify this value, the RUC reviewed the reference code 17315 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of*

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specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (work RVU= 0.87) and agreed that while the two services have identical intra-service time of 30 minutes, the surveyed code is a more complex procedure and should be valued slightly higher than the reference code. **The RUC recommends a work RVU of 0.92 for CPT code 95886.**

95887 ***Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study***

The RUC reviewed the survey results from 63 physicians for CPT code 95887. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (work RVU= 0.73) and agreed that the two services have similar physician work and identical intra-service time of 20 minutes. Given the similarities, the RUC recommends the work value for 95887 be directly crosswalked to the reference code's work RVU of 0.73. To further justify this value, the RUC reviewed reference code 76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (work RVU= 0.74) and agreed that the two services have comparable physician work and intensity with identical intra-service time of 20 minutes. **The RUC recommends a work RVU of 0.73 for CPT code 95887.**

95900 ***Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study***

The RUC reviewed the survey results from 64 physicians for CPT code 95900. The RUC recommends maintaining the current RUC reviewed pre-service time of 4 minutes, intra-service time of 6 minutes and post-service time of 4 minutes. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. Given that there is no compelling evidence to suggest the physician work has changed for this service, the RUC recommends the current work RVU of 0.42 for this service. To justify this value, the RUC looked at the MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and agreed that these service are comparable but given that the reference code has great intra-service time, 10 minutes compared to 6 minutes, the surveyed code should be valued lower. **The RUC recommends a work RVU of 0.42 for CPT code 95900.**

95903 ***Nerve conduction, amplitude and latency/velocity study, each nerve; motor, motor, with F-wave study***

The RUC reviewed the survey results from 64 physicians for CPT code 95903. The RUC recommends pre-service time of 4 minutes, intra-service time of 10 minutes and post-service time of 4 minutes. The pre-service and post-service time components were reduced from the survey median values to match the analogous physician work of 95900. The RUC noted there is no compelling evidence to suggest the physician work has changed for this service and recommends the current work RVU of 0.60 for this code. To justify this value, the RUC looked at the key reference service 95937 *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method* (work RVU= 0.65) and agreed that these services have analogous physician work and intensity. The RUC determined that 95937 has greater intra-service time compared to the surveyed code, 12 minutes and 10 minutes, respectively, therefore the surveyed code should be valued slightly less. Finally, the RUC noted that the current work RVU of 0.60 is supported by the survey's 25th percentile at the same value. **The RUC recommends a work RVU of 0.60 for CPT code 95903.**

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95904 ***Nerve conduction, amplitude and latency/velocity study, each nerve; motor, motor, sensory***
The RUC reviewed the survey results from 66 physicians for CPT code 95904. The RUC recommends maintaining the current RUC reviewed pre-service time of 4 minutes, intra-service time of 5 minutes and post-service time of 3 minutes. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. Given that there is no compelling evidence to suggest the physician work has changed for this service, the RUC recommends the current work RVU of 0.34 for this service. To justify this value, the RUC reviewed CPT code 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination* (work RVU= 0.30) and agreed that since the surveyed code has greater total time than the reference code, 12 minutes compared to 10 minutes, 95904 should be valued slightly higher than the reference code. **The RUC recommends a work RVU of 0.34 for CPT code 95904.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. The direct inputs recommended by the specialty for codes 95900, 95903, and 95904 were not accepted and the existing inputs are to be maintained. In addition, the RUC recommended the codes be sent to CPT for revision. For all other codes the clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services. Supplies and equipment were also reviewed carefully and modified where appropriate.

Additional Discussion
The RUC affirmed that the valuation for CPT codes 95900, 95903 and 95904 is appropriate given the current survey data and review. However, if the specialty should obtain compelling evidence through additional data sources they should not be precluded from requesting a review of these services (i.e. Five-Year Review).

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CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Neurology and Neuromuscular Procedures** **Electromyography** Needle electromyographic (EMG) procedures include the interpretation of electrical waveforms measured by equipment that produces both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode. Use 95870 or 95885 when four or fewer muscles are tested in an extremity. Use 95860-95864 or 95886 when five or more muscles are tested in an extremity. Use EMG codes (95860-95864 and 95867-95870) when no nerve conduction studies (95900-95904) are performed on that day. Use 95885, 95886 and 95887 for EMG services when nerve conduction studies (95900-95904) are performed in conjunction with EMG on the same day. Report either 95885 or 95886 once per extremity. Codes 95885 and 95886 can be reported together up to a combined total of four units of service per patient when all four extremities are tested.				
#● +95885	GG1	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	ZZZ	0.35
#● +95886	GG2	complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure) (Use 95885, 95886 in conjunction with 95900-95904) (Do not report 95885, 95886 in conjunction with 95860-95864, 95870, 95905)	ZZZ	0.92
#● +95887	GG3	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure) (Use 95887 in conjunction with 95900-95904) (Do not report 95887 in conjunction with 95867-95870, 95905)	ZZZ	0.73

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Neurology and Neuromuscular Procedures** **Nerve Conduction Tests**				
E⃠95900	GG4	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	XXX	0.42 (No Change)
E ⃠95903	GG5	motor, with F-wave study	XXX	0.60 (No Change)
E ⃠95904	GG6	sensory (Report 95900, 95903, and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded) (Use 95885-95887 in conjunction with 95900-95904 when performing electromyography with nerve conduction studies)	XXX	0.34 (No Change)
E ⃠95905	GG7	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report (Report 95905 only once per limb studied) (Do not report 95905 in conjunction with 95885, 95886, 95900-95904, 95934-95936)	XXX	N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95885 Tracking Number GG1 Original Specialty Recommended RVU: **0.34**
Presented Recommended RVU: **0.35**
Global Period: ZZZ RUC Recommended RVU: **0.35**

CPT Descriptor: Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old woman has a five month history of frequent awakening at night due to right hand and arm pain. Prolonged typing also causes distal right upper extremity numbness, tingling and pain and she sometimes drops things out of the right hand. Physical examination reveals numbness of the palmar aspects of the right index and middle fingers; and a questionable Tinel's sign over the right median nerve at the carpal tunnel. Three motor and four sensory nerve conduction studies were performed. Right median sensory nerve conduction is slowed across the carpal tunnel. Needle electromyography examination of a thenar muscle innervated by the median nerve of the symptomatic limb is indicated, along with an ulnar and radial-innervated muscle to confirm the diagnosis of median neuropathy at the wrist, evaluate severity, and rule out more widespread pathology.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the needle EMG test with the patient and answering questions regarding the pain associated with the procedure. The physician must specifically assess the risk of the procedure (e.g., bleeding, infection) by reviewing the patient's medical history and medications. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Four or fewer muscles are

examined individually using the steps outlined above. The muscles are located in an upper or lower extremity and its related cervical or lumbar paraspinal areas.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Kevin Kerber, MD and Marianna Spanaki, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)					
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA					
CPT Code:	95885					
Sample Size:	480	**Resp N:**	88	**Response:** 18.3 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**175.00**	478.00	1300.00
Survey RVW:	0.37	0.90	**1.50**	2.00	5.00
Pre-Service Evaluation Time:			**7.50**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	15.00	**22.50**	40.00	80.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	95885	**Recommended Physician Work RVU: 0.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95861	XXX	1.54	**RUC Time**

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,660,131

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 42 **% of respondents:** 47.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 95885**	**Key Reference CPT Code:** 95861	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.64	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.52
Urgency of medical decision making	3.14	3.21
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.17	4.19
Physical effort required	3.21	3.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.52	2.62
Outcome depends on the skill and judgment of physician	4.19	4.19
Estimated risk of malpractice suit with poor outcome	2.57	2.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.81	2.81
Intra-Service intensity/complexity	3.86	3.93
Post-Service intensity/complexity	3.07	3.05

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations.

While there were a large number of survey respondents, the high times and RVW show there was likely confusion about regarding this service as an add-on EMG only.
The panel considered the existing work value for the corresponding stand-alone limited EMG (95870) which is 0.37 and recommends decreasing the value to 0.34 RVW to reflect the amount of duplication in work of providing the nerve conduction base code and the EMG service. The panel determined 15 minutes was an appropriate intra-service time. When reviewing the needle EMG tests in summary, the panel ensured there were not rank order anomalies with the times or RVW.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached Table 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This is a new add-on code that reflects similar work to the existing stand-alone code 95870.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty PM&R How often? Commonly

Specialty Physical Therapy How often?

Estimate the number of times this service might be provided nationally in a one-year period? 245068
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated four times the Medicare utilization.

Specialty Neurology Frequency 168386 Percentage 68.70 %

Specialty PM&R Frequency 63423 Percentage 25.87 %

Specialty Physical Therapy Frequency 564 Percentage 0.23 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
60,654 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. This is based on the 2009 Medicare utilization of CPT code 95870, though a small percentage of 95870 will continue to be reported as stand-alone EMGs.

Specialty Neurology	Frequency 42102	Percentage 68.71 %
Specialty PM&R	Frequency 15862	Percentage 25.88 %
Specialty Physical Therapy	Frequency 141	Percentage 0.23 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95870

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95886 Tracking Number GG2 Original Specialty Recommended RVU: **0.90**
Presented Recommended RVU: **0.92**
Global Period: ZZZ RUC Recommended RVU: **0.92**

CPT Descriptor: Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels
(List separately in addition to code for primary procedure)
(Use 95885, 95886 in conjunction with 95900-95904)
(Do not report 95885, 95886 in conjunction with 95860-95864, 95870, 95905)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old diabetic man has a two month history of pain, numbness, and tingling of the left upper extremity. There was no preceding injury and there are no clear cut provocative or palliative factors. Physical examination reveals no definite motor, sensory or reflex abnormalities. Three motor and four sensory nerve conduction studies were performed. No abnormalities are noted on these studies. Needle electromyography examination of at least 1 muscle innervated by the C5, C6, C7, C8, and T1 spinal roots in the symptomatic limb, and cervical paraspinal muscles at 1 or more levels, is indicated to evaluate for mononeuropathy, peripheral neuropathy, brachial plexopathy, or cervical radiculopathy as a cause for these symptoms.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the needle EMG test with the patient and answering questions regarding the pain associated with the procedure. The physician must specifically assess the risk of the procedure (e.g., bleeding, infection) by reviewing the patient's medical history and medications. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration,

amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Five or more muscles are examined individually using the steps outlined above. The muscles are located in an upper or lower extremity and its related cervical or lumbar paraspinal areas, and are innervated by three or more nerves or four or more spinal levels.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)					
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA					
CPT Code:	95886					
Sample Size:	481	**Resp N:**	74	**Response:** 15.3 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	150.00	**250.00**	500.00	2200.00
Survey RVW:	0.48	1.20	**1.54**	2.38	6.30
Pre-Service Evaluation Time:			**9.50**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	20.00	**30.00**	45.00	65.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	95886	**Recommended Physician Work RVU: 0.92**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95861	XXX	1.54	**RUC Time**

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11100	000	0.81	**RUC Time**	2,579,687

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,352,028

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 48.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 95886**	**Key Reference CPT Code:** 95861	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.31	4.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.19	4.08
Urgency of medical decision making	3.69	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.50	4.33
Physical effort required	3.28	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.22	3.17
Outcome depends on the skill and judgment of physician	4.56	4.44
Estimated risk of malpractice suit with poor outcome	3.00	2.97

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.36	3.39
Intra-Service intensity/complexity	4.33	4.28
Post-Service intensity/complexity	3.47	3.50

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations.

While there were a large number of survey respondents, the high times and RVW show there was likely confusion about the actual work involved in this service as an add-on EMG only.
The panel looked at the existing work value for the stand-alone complete one limb needle EMG (95860) which is 0.96 and recommends decreasing the value to 0.92 RVW to reflect a duplication in work when providing the nerve conduction base code and the EMG add-on code. The panel determined 30 minutes was an appropriate intra-service time. When reviewing the needle EMG tests in summary, the panel ensured there were not rank order anomalies with the times or RVW.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached Table 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This is a new add-on code that reflects similar work to the existing stand-alone code 95860.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty PM&R How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1052808
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated four times the Medicare utilization.

Specialty Neurology Frequency 665796 Percentage 63.24 %

Specialty PM&R Frequency 323423 Percentage 30.72 %

Specialty Physical Therapy Frequency 6528 Percentage 0.62 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 646,904 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 2009 Medicare utilization of 95860, 61, 63, 64.

Specialty Neurology	Frequency 407552	Percentage 63.00 %
Specialty PM&R	Frequency 194075	Percentage 30.00 %
Specialty Physical Therapy	Frequency 4974	Percentage 0.76 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95860

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95887 Tracking Number GG3 Original Specialty Recommended RVU: **0.48**
Presented Recommended RVU: **0.73**
Global Period: ZZZ RUC Recommended RVU: **0.73**

CPT Descriptor: Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)
(Use 95887 in conjunction with 95900-95904)
(Do not report 95887 in conjunction with 95867-95870, 95905)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman has a two month history of right facial weakness involving the forehead, eyelid and mouth. Initially she was treated with steroids for a presumptive diagnosis of Bell's palsy, but her deficits persisted. Physical examination demonstrates a peripheral distribution right facial palsy. Right facial motor nerve conduction study was abnormal due to prolonged distal motor latency and low compound muscle action potential amplitude. Needle electromyography of right cranial nerve innervated muscles (V, VII, XI, XII) is indicated to confirm the diagnosis, help establish the prognosis and determine the need for facial nerve decompression.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the needle EMG test with the patient and answering questions regarding the pain associated with the procedure. The physician must specifically assess the risk of the procedure (e.g., bleeding, infection) by reviewing the patient's medical history and medications. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Cranial nerve innervated

muscles (eg, face or tongue muscles) or axial muscles (eg, serratus anterior or thoracic paraspinal muscles) on one side of the body are examined individually using the steps outlined above. Special care must be taken during the study since many muscles are thin and located adjacent to critical structures (eg, eye or lung).

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)					
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA					
CPT Code:	95887					
Sample Size:	482	**Resp N:**	63	**Response:** 13.0 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	25.00	1000.00
Survey RVW:	0.48	0.81	**1.20**	1.73	3.30
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	95887	**Recommended Physician Work RVU: 0.73**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95861	XXX	1.54	**RUC Time**

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**Harvard Time**	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,660,131

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 29 **% of respondents:** 46.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95887**	**Key Reference CPT Code:** 95861	**Source of Time** RUC Time
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.52	4.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.52	4.28
Urgency of medical decision making	4.17	3.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.90	4.62
Physical effort required	3.62	3.52
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.79	3.28
Outcome depends on the skill and judgment of physician	4.86	4.66
Estimated risk of malpractice suit with poor outcome	3.59	3.21

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.69	3.52
Intra-Service intensity/complexity	4.48	4.52
Post-Service intensity/complexity	3.79	3.66

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations.

While there were a large number of survey respondents, the high times and RVW show there was likely confusion about the actual work involved in this service as an add-on EMG only code.
This code represents the work of several current stand-along needle EMG codes, including 95867 (0.79 RVW), 95869 (0.37 RVW) and part of 95870 (0.37 RVW). The panel recommends a value of 0.73 RVW to reflect the amount of duplication in work when providing the nerve conduction base code and the EMG service. The panel determined 20 minutes was an appropriate intra-service time. When reviewing the needle EMG tests in summary, the panel ensured there were not rank order anomalies with the times or RVW. When compared with 95885, 95886 involves increased risk because of the areas involved in the test (e.g., face and paraspinal muscles).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached table 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Either 95867, 95868, 95869, or 95870

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty PM&R How often? Sometimes

Specialty Physical Therapy How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 50292
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated four times the Medicare utilization.

Specialty Neurology Frequency 39394 Percentage 78.33 %

Specialty PM&R Frequency 7338 Percentage 14.59 %

Specialty Physical Therapy Frequency 110 Percentage 0.21 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 12,573 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 2009 Medicare utilization of 95867, 95868, and 95869, though a small percentage of those services will continue to be reported as stand-alone EMGs.

Specialty Neurology Frequency 9849 Percentage 78.33 %

Specialty PM&R Frequency 1835 Percentage 14.59 %

Specialty Physical Therapy Frequency 28 Percentage 0.22 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95860

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95900 Tracking Number GG4 Original Specialty Recommended RVU: **0.42**
Presented Recommended RVU: **0.42**
Global Period: XXX RUC Recommended RVU: **0.42**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents to the clinic with weakness of the right quadriceps muscle and pain over the right hip. Based on the examination, a traumatic femoral neuropathy is suspected. A motor nerve conduction study without f-wave of the right femoral nerve is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 1%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical questions. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes physician performance or supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveform of the resulting compound muscle action potentials. The waveform is analyzed with respect to latency, amplitude and configuration. Interelectrode distances are measured and recorded. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves calculation of nerve conduction velocities, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)		
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA		
CPT Code:	95900		
Sample Size:	485	**Resp N:** 64	**Response:** 13.1 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**245.00**	1050.00	6000.00
Survey RVW:	0.18	0.50	**0.65**	1.10	2.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	5.00	**10.00**	15.00	45.00

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	95900	**Recommended Physician Work RVU: 0.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**4.00**	**0.00**	**4.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**6.00**		

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95937	XXX	0.65	**RUC Time**

CPT Descriptor Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,660,131

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 39.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95900**	**Key Reference CPT Code:** 95937	**Source of Time** **RUC Time**
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	6.00	12.00	
Median Immediate Post-service Time	4.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**14.00**	**0.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.16	4.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.12
Urgency of medical decision making	3.96	4.12
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.24	4.40
Physical effort required	3.40	3.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.80	2.80
Outcome depends on the skill and judgment of physician	4.52	4.48
Estimated risk of malpractice suit with poor outcome	2.84	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.48	3.68
Intra-Service intensity/complexity	4.04	4.16
Post-Service intensity/complexity	3.48	3.52

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations. While the survey data showed higher times and RVWs, the panel felt there was not evidence

that more time was involved in performing the service and the work had not changed since the code was valued in 2005. The panel supports the existing RUC times and RVW of 0.42.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See Table 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95900

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty PM&R How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 5484340
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at four times the Medicare utilization.

Specialty Neurology Frequency 2922604 Percentage 53.28 %

Specialty PM&R Frequency 1671626 Percentage 30.47 %

Specialty Physical Therapy Frequency 33454 Percentage 0.60 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,371,085 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 2009 Medicare data.

Specialty Neurology Frequency 730788 Percentage 53.29 %

Specialty PM&R Frequency 418043 Percentage 30.48 %

Specialty Physical Therapy Frequency 8500 Percentage 0.61 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95900

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95903 Tracking Number GG5 Original Specialty Recommended RVU: **0.60**
Presented Recommended RVU: **0.60**
Global Period: XXX RUC Recommended RVU: **0.60**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman presents with 3 months of weakness and numbness of her arms and legs. Physical examination shows weakness of distal upper and lower limb muscles, areflexia and sensory loss. Axonal or demyelinating polyneuropathies are suspected. Motor nerve conduction studies with f-waves in the upper and lower limbs are indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 1%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addrresses the relevant clinical questions. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studies are then determined

Description of Intra-Service Work: Intra-service work includes physician performance or supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveform of the resulting compound muscle action potentials. The waveform is analyzed with respect to latency, amplitude and configuration. Interelectrode distances are measured and recorded. F-wave studies involve changing the electromyograph's gain setting, time base and filter settings (sometimes), reorienting the stimulating electrode (sometimes) and stimulating motor nerves enough times to generate more than 10 F-waves, which are recorded and analyzed. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves calculation of nerve conduction velocities, sometimes calculation of certain F-wave indices that are more sensitive than raw F-wave latencies, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)					
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA					
CPT Code:	95903					
Sample Size:	481	**Resp N:**	65	**Response:** 13.5 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	100.00	**360.00**	1000.00	5400.00
Survey RVW:	0.25	0.60	**0.78**	1.38	3.70
Pre-Service Evaluation Time:			**8.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	8.00	**15.00**	30.00	75.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	95903	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**4.00**	**0.00**	**4.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95937	XXX	0.65	**RUC Time**

CPT Descriptor Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,660,131

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99462	XXX	0.62	**RUC Time**	15

CPT Descriptor 2 Subsequent hospital care, per day, for evaluation and management of normal newborn

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 41.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 95903**	**Key Reference CPT Code:** 95937	**Source of Time** **RUC Time**
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	10.00	12.00	
Median Immediate Post-service Time	4.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**18.00**	**22.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.41	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.30
Urgency of medical decision making	4.04	4.04
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.41	4.56
Physical effort required	3.67	3.81
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.19	3.07
Outcome depends on the skill and judgment of physician	4.63	4.56
Estimated risk of malpractice suit with poor outcome	3.22	3.19

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.59	3.67
Intra-Service intensity/complexity	4.19	4.30
Post-Service intensity/complexity	3.70	3.74

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations. While the survey data showed higher times and RVWs, the panel felt there was not evidence

that more time was involved in performing the service and the work had not changed since the code was valued at the RUC. The panel supports the existing RUC times and RVW of 0.60.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See table 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95903

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty PM&R How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 8592492
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national frequency as 4 times the Medicare utilization.

Specialty Neurology Frequency 4458644 Percentage 51.88 %

Specialty PM&R Frequency 1082653 Percentage 12.59 %

Specialty Physical Therapy Frequency 46399 Percentage 0.53 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,148,123 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 2009 Medicare data.

Specialty Neurology Frequency 1114875 Percentage 51.89 %

Specialty PM&R Frequency 270878 Percentage 12.60 %

Specialty Physical Therapy Frequency 11750 Percentage 0.54 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95903

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95904 Tracking Number GG6 Original Specialty Recommended RVU: **0.34**
Presented Recommended RVU: **0.34**
Global Period: XXX RUC Recommended RVU: **0.34**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
(Report 95900, 95903, and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded)
(Use 958XX-958ZZ with 95900-95904 when performing electromyography with nerve conduction studies)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year woman with no significant past medical history presents with three months of tingling and numbness in both lower limbs distally and in the left more than right hand. Physical examination shows normal strength, loss of pin prick and vibration over the feet, lower legs, and fingers bilaterally, as well as absent ankle reflexes. A disorder affecting sensorimotor nerves or a neuronopathy is suspected. Motor nerve conduction studies show normal distal lower and upper limb nerve conduction values. Sensory nerve conduction studies are recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 1%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addrresses the relevant clinical questions. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. After identifying anatomic landmarks, the physician (and/or the technologist) cleans the skin overlying anticipated nerve stimulation and recording sites and places the recording electrodes and ground surface electrodes. Electrical stimuli are delivered via the surface stimulating electrode prongs; this includes searching for the optimal site by the obtained response, rotating the prongs to secure the proper shape of waveform on the EMG machine screen, and constantly communicating with the patient in an effort to reduce muscle artifact. Reporting procedures are explained to the patient.

Description of Post-Service Work: Post-service work involves assessing the waveforms from each sensory nerve tested, summarization of clinical and electrodiagnostic data, writing the physician interpretation, generation of a differential diagnosis, and sometimes providing suggestions for further investigations.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)		
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA		
CPT Code:	95904		
Sample Size: 484	**Resp N:** 66	**Response:** 13.6 %	
Sample Type: Panel	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	300.00	**800.00**	2000.00	8000.00
Survey RVW:	0.16	0.40	**0.59**	1.18	2.80
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**10.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95904	**Recommended Physician Work RVU: 0.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**4.00**	**0.00**	**4.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**3.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95937	XXX	0.65	**RUC Time**

CPT Descriptor Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,660,131

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 34.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 95904**	**Key Reference CPT Code:** 95937	**Source of Time** **RUC Time**
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	5.00	12.00	
Median Immediate Post-service Time	3.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**12.00**	**22.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.26	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.26	4.48
Urgency of medical decision making	4.13	4.22
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.43	4.57
Physical effort required	3.57	3.74
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.13	3.13
Outcome depends on the skill and judgment of physician	4.61	4.57
Estimated risk of malpractice suit with poor outcome	3.26	3.17

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.91	3.91
Intra-Service intensity/complexity	4.13	4.30
Post-Service intensity/complexity	3.83	3.91

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations. While the survey data showed higher times and RVWs, the panel felt there was not evidence

that more time was involved in performing the service and the work had not changed since the code was valued in 2005. The panel supports the existing RUC times and RVW of 0.34.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See Table 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95904

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty PM&R How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 14382148
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national frequency at 4 times Medicare utilization.

Specialty Neurology Frequency 7271614 Percentage 50.55 %

Specialty PM&R Frequency 2863485 Percentage 19.90 %

Specialty Physical Therapy Frequency 86293 Percentage 0.60 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,595,537 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 2009 Medicare data.

Specialty Neurology Frequency 1818263 Percentage 50.56 %

Specialty PM&R Frequency 716230 Percentage 19.91 %

Specialty Physical Therapy Frequency 21932 Percentage 0.60 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95904

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95885 Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

Global Period: _ZZZ_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The panel looked at existing PE inputs for a similar service (95870) as a basis for the new code, and modified them to reflect current PE Subcommittee conventions.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
No pre-service time as the code is an add-on.

Intra-Service Clinical Labor Activities:
The additional components of the EMG test are explained to the patient, and the patient is asked if they wish to proceed. The patient's medical history is reviewed so that the risks of the procedure (eg, bleeding or pain) can be properly assessed. Notes are taken during the test regarding the results.

Post-Service Clinical Labor Activities:
No pre-service time as the code is an add-on.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Nerve Conduction Tests

The CPT Editorial Panel created one new Category I CPT code to describe a new nerve conduction test performed with newer technologies that differ from traditional technologies. The Editorial Panel created, 95905, *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report* at its October 2008 Meeting. The Editorial Panel specified that this codes may be reported only once per limb studied.

The specialty societies presented survey data from 75 physicians; however, the median service performance rate of all surveyees was zero. Following RUC policy, the specialties provided additional data from their original survey, including the compilation of responses from physicians with a service performance rate of at least one and the compilation of responses from physicians with a service performance rate of zero, which the RUC compared with the aggregate data in the Summary of Recommendation form. The specialties also provided a complete description of the work that is included in the procedure to support the contention that there is physician work involved since it was noted that 21 of the survey respondents compared the new code to a reference code with no physician work. Based on this description and the overall survey results, the RUC agreed that although the median survey work RVUs and some of the surveyed physician times are inflated, a small amount of physician work is appropriate. The RUC reviewed the times recommended by the specialties and noted that there is no pre-service or post-service physician time and that the physician work is only performed during the intra-service period. Specifically, the RUC decided that the physician work described by the specialties within the pre-service time is included within the evaluation and management service that is typically reported on the same day and that the physician work described by the specialties within the post-service time is inappropriate and is included within the five minutes of intra-service time. The RUC compared 95905 to 76977, *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05, intra-service = 5 minutes), which is identical in physician time and work. The RUC agreed that 76977 serves as a direct comparison code and the appropriate work RVU for 95905 is 0.05, based on this magnitude estimation. The Committee also noted that 0.05 is the survey 25th percentile work RVU. The RUC also commented that this service is Modifier 51 exempt and assumed it may often be reported more than once, supporting pre- and post-service times of 0 minutes. **Therefore, the RUC recommends a work RVU of 0.05, no pre- or post-service time and five minutes of intra-service time for 95905.**

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Practice Expense
The RUC reviewed the practice expense inputs and revised the clinical staff time to reflect that multiple units of services are typically reported.

PLI
The RUC recommends a PLI crosswalk to the key reference service, 76977-26 (the professional component only).

New Technology
The RUC recommends that 95905 is placed on the New Technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
The following applies to nerve conduction tests (95900-95904): Codes 95900-95904 describe nerve conduction tests when performed with individually placed stimulating, recording, and ground electrodes. The stimulating, recording, and ground electrode placement and the test design must be individualized to the patient's unique anatomy. Nerves tested must be limited to the specific nerves and conduction studies needed for the particular clinical question being investigated. The stimulating electrode must be placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, and in some sensory and mixed nerve conduction studies, both proximal and distal stimulation will be used. Motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested. Waveforms must be reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) must be adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Reports must be prepared on site by the examiner, and consist of the work product of the interpretation of numerous test results, using well-established techniques to assess the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of each nerve tested. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values, summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation. Code 95905 describes nerve conduction tests when performed with preconfigured electrodes customized to a specific anatomic site.				

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95900		Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	XXX	0.42 (No Change)
●95905	M1	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report (Report 95905 only once per limb studied) (Do not report 95905 in conjunction with 95900-95904, 95934-95936)	XXX	0.05

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95905 Tracking Number M1 Specialty Society Recommended RVU: **0.15**

Global Period: XXX RUC Recommended RVU: **0.05**

CPT Descriptor: Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report
(Report 95905 only once per limb studied)
(Do not report 95905 in conjunction with 95900-95904, 95934-95936)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old female data entry clerk reported that, although she had had no injuries and during the day she was okay, she had been awakened in the middle of each night for the past two weeks with a numb, aching, burning feeling in her right hand that was relieved by holding her hand down and shaking it, rubbing it and running cold water over it. Physical examination reveals weakness of right thumb abduction, wasting of the right thenar eminence, numbness of the palmar aspects of the right thumb, index finger and middle finger, and a Tinel's sign over the right median nerve at the carpal tunnel. (History and exam reported separately as E/M). Nerve conduction testing using preconfigured arrays for the right arm is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician reviews a summary of electrodiagnostic data from each nerve tested and assesses it in the context of comparison to normal values and the patient's history and physical examination.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Gregory Barkley, MD (AAN); Andrea Boon, MD (AANEM); Neil Busis, MD (AAN); Lee Mills, MD (AAFP); John A. Seibel, MD, MACE (AACE); Benn Smith, MD (AANEM)					
Specialty(s):	American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Association of Clinical Endocrinologists (AACE), American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), American Clinical Neurophysiology Society (ACNS)					
CPT Code:	95905					
Sample Size:	380	**Resp N:**	75	**Response:** 19.7 %		
Sample Type:	Panel					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	4.50	933.00
Survey RVW:	0.00	0.05	**0.15**	0.40	45.50
Pre-Service Evaluation Time:			**3.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	0.50	**5.00**	10.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	95905	**Recommended Physician Work RVU: 0.05**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92586	XXX	0.00	

CPT Descriptor AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM; LIMITED

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95165	XXX	0.06	**RUC Time**	5,839,746

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	20,245,535

CPT Descriptor 2 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Other Reference CPT Code	Global	Work RVU	Time Source
93000	XXX	0.17	**RUC Time**

CPT Descriptor Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 28.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 95905**	**Key Reference CPT Code:** 92586	**Source of Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	5.00	0.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**5.00**	**0.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.81	2.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.48	1.95
Urgency of medical decision making	1.38	1.76

Technical Skill/Physical Effort (Mean)

Technical skill required	1.33	2.33
Physical effort required	1.19	1.76

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.24	1.71
Outcome depends on the skill and judgment of physician	1.67	2.29
Estimated risk of malpractice suit with poor outcome	2.10	1.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	1.24	1.48
Intra-Service intensity/complexity	1.19	1.90
Post-Service intensity/complexity	1.43	2.10

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey received 75 responses from among the 5 surveying societies.

Since the majority of respondents have not performed this service, the group also examined survey data based on only those who had performed the service in the last year. Based on that data, the median RVW was 0.17 and the times were 3 minutes pre-service, 5 minutes intra-service, and 5 minutes post-service. The results were very similar to the complete survey data.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is typically reported on the same day as an E/M service.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT Code	Global Period	RVW	Pre-time	Intra-time	Post-time	Total Time
9590X1	XXX	?	3	5	4	12
99213	XXX	0.92	3	15	5	23

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95900, 95903, 95904

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Physicians How often? Sometimes

Specialty Endocrinology How often? Sometimes

Specialty Neurology How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 4000000
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We multiplied our estimates for Medicare times 4 to estimate national utilization.

Specialty Family Physicians Frequency 2500000 Percentage 62.50 %

Specialty Endocrinology Frequency 1495000 Percentage 37.37 %

Specialty Neurology Frequency 5000 Percentage 0.12 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000,000 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. We examined Medicare utilization data of 95900, 95903, and 95904 by family practice and internal medicine for 2006 and estimated most of the codes would have been reported for automated nerve testing services.

Specialty Family Physicians Frequency 625000 Percentage 62.50 %

Specialty Endocrinology Frequency 373750 Percentage 37.37 %

Specialty Neurology Frequency 1250 Percentage 0.12 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 76977-26

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report
(Report 95905 only once per limb studied)
(Do not report 95905 in conjunction with 95900-95904, 95934-95936)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The RUC advisors from the five specialty societies that surveyed the physician work involved with this code formed a joint RVS panel to formulate the recommendations regarding direct practice expense inputs. The joint RVS panel met twice by conference call and also exchanged information by e-mail. The panel members relied on their own experience and knowledge of the service to formulate the recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MA:

Intra-Service Clinical Labor Activities:

RN/LPN/MA: Reviews test orders and relevant clinical information. Files pre-authorization paperwork if necessary. Ensures adequate supply of electrodes for the ordered testing. Escorts patient from registration area to exam site and instructs patient on appropriate limb exposure, gowning if necessary. Explains testing procedure, purpose, and side effects. Positions patient for study, then cleans and preps indicated limb. Stimulating and recording surface electrode components of the nerve specific pre-configured electrode arrays are placed. Testing involves automated stimulation of nerves and recording of the waveforms of the resulting compound muscle or sensory nerve action potentials. The waveforms are transmitted electronically for computer generated analysis with respect to latency, amplitude, and configuration. Provides discharge instructions. Gathers data report and clinical information for interpretation by physician. Tracks and reorders electrode supplies as needed. Performs internal Q/A activity.

Post-Service Clinical Labor Activities:

RN/LPN/MA:

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**95905**	
2	**Meeting Date: January 29 - February 1, 2009**	**CMS**	**Staff**	**Motor and/or sensory nerve conduction, using preconfigured electrode**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**	**XXX**			
5	**TOTAL CLINICAL LABOR TIME**			**8.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms			**0**	**0**
12	Coordinate pre-surgery services				
13	Schedule space and equipment in facility				
14	Provide pre-service education/obtain consent				
15	Follow-up phone calls & prescriptions				
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review charts			**0**	
21	Greet patient and provide gowning				
22	Obtain vital signs				
23	Provide pre-service education/obtain consent			**1**	
24	Prepare room, equipment, supplies			**2**	
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV				
27	Sedate/apply anesthesia				
28	**Intra-service**				
29	Perform the test			**4**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff				
33	Clean Scope				
34	Clean Surgical Instrument Package				
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Uploading and restore equipment to docking station			**1**	
38	Discharge day management				
39	Other Clinical Activity (please specify)				
40	**End: Patient leaves office**				
41	**POST-SERVICE Period**				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions				
44	*Office visits:* ***None***				
51	Other				
52	*Total Office Visit Time*			**0**	**0**
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**		**Unit**		
56	preconfigured nerve electrode array	NEW	array	**1**	**0**
57	paper, exam table	SB036	foot	**0**	
58	swab-pad, alcohol	SJ053	item	**2**	
59	**Equipment**				
60	table, exam	EF023		**8**	**0**
61	automated nerve conduction testing device (e.g., NC-stat® System)	NEW		**8**	**0**

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95886 Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

Global Period: _ZZZ_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The panel looked at existing PE inputs for a similar service (95860) as a basis for the new code, and modified them to reflect current PE Subcommittee conventions.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
No pre-service time as the code is an add-on.

Intra-Service Clinical Labor Activities:
The additional components of the EMG test are explained to the patient, and the patient is asked if they wish to proceed. The patient's medical history is reviewed so that the risks of the procedure (eg, bleeding or pain) can be properly assessed. Notes are taken during the test regarding the results.

Post-Service Clinical Labor Activities:
No pre-service time as the code is an add-on.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

Global Period: _ZZZ_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The panel looked at existing PE inputs for similar services (95867, 95869, and 95870) as a basis for the new code, and modified them to reflect current PE Subcommittee conventions.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
No pre-service time as the code is an add-on.

Intra-Service Clinical Labor Activities:
The additional components of the EMG test are explained to the patient, and the patient is asked if they wish to proceed. The patient's medical history is reviewed so that the risks of the procedure (eg, bleeding or pain) can be properly assessed. Notes are taken during the test regarding the results.

Post-Service Clinical Labor Activities:
No pre-service time as the code is an add-on.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Global Period:_XXX_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The panel looked at existing PE inputs for the service as approved in 1999 and modified them to reflect current PE Subcommittee conventions and current typical inputs for the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Intra-Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated.The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed.The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. Thepatient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing.The patient is instructed to disrobe,and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test,presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:
The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers. Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95903 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, withF-wave study

Global Period:_XXX_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The panel looked at existing PE inputs for the service as approved in 2000 and modified them to reflect current PE Subcommittee conventions and current typical inputs for the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Intra-Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated.The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed.The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. Thepatient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing.The patient is instructed to disrobe,and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:
The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area.. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers. Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record or mailed to the outside referring physician.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory

Global Period:_XXX_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The panel looked at existing PE inputs for the service as approved in 1999 and modified them to reflect current PE Subcommittee conventions and current typical inputs for the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Intra-Service Clinical Labor Activities:
The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated.The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed.The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. Thepatient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing.The patient is instructed to disrobe,and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:
The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers. Forms/data sheets are printed, collected, and brought to the administrative/interpretation area.After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

	A	B	C	D	E	F
1				**95900**	**95903**	**95904**
2	**Meeting Date: April 2011** **AMA Specialty Society RVS Update Committee Recommendation** **RECOMMENDATION TO MAINTAIN EXISTING DIRECT PE INPUTS**	**CMS**	**Staff**	Nerve conduction,...; motor, without F-wave study	Nerve conduction,...; motor, with F-wave study	Nerve conduction, ..., each nerve; sensory
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**	**L037A**	**Electrodx Tec**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**24.0**	**30.0**	**24.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**24.0**	**30.0**	**24.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**					
10	**Start: Following visit when decision for surgery or procedure made**					
11	Complete pre-service diagnostic & referral forms					
12	Coordinate pre-surgery services					
13	Schedule space and equipment in facility					
14	Provide pre-service education/obtain consent					
15	Follow-up phone calls & prescriptions					
16	Other Clinical Activity (please specify)					
17	**End: When patient enters office/facility for surgery/procedure**					
18	**SERVICE PERIOD**					
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
20	Greet patient, provide gowning, ensure appropriate medical records are available					
21	Obtain vital signs					
22	Provide pre-service education/obtain consent					
23	Prepare room, equipment, supplies					
24	Setup scope (non facility setting only)					
25	Prepare and position patient/ monitor patient/ set up IV					
26	Sedate/apply anesthesia					
27	**Intra-service**					
29	Assist physician in performing procedure					
32	**Post-Service**					
33	Monitor pt. following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff					
35	Clean and sterilize electrodes.					
36	Complete medical record, and archive data.					
39	Complete diagnostic forms, lab & X-ray requisitions					
44	**End: Patient leaves office**					
45	**POST-SERVICE Period**					
46	**Start: Patient leaves office/facility**					
47	Conduct phone calls/call in prescriptions					
58	**End: with last office visit before end of global period**					

	A	B	C	D	E	F
1				**95900**	**95903**	**95904**
2	**Meeting Date: April 2011** **AMA Specialty Society RVS Update Committee Recommendation** **RECOMMENDATION TO MAINTAIN EXISTING DIRECT PE INPUTS**	**CMS**	**Staff**	Nerve conduction,...; motor, without F-wave study	Nerve conduction,...; motor, with F-wave study	Nerve conduction, ..., each nerve; sensory
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
59	**MEDICAL SUPPLIES**	**Code**				
62	electrode, bar-style (single)	SD052			1	
63	electrode, ground	SD059		1	1	1
64	drape, non-sterile, sheet 40in x 60 in	SB006		1	1	1
65	gloves, non-sterile	SB022		2	2	1
66	gown, patient	SB026		1	1	1
67	paper, exam table	SB036		7	7	7
68	paper, recording (per sheet)	SK059		1	1	
69	electrode conductive gel	SJ020		5	5	5
70	swab-pad, alcohol	SJ053		2	2	2
72	gauze, sterile 4in x 4in	SG055		2	2	2
73	tape, surgical paper 1in (Micropore)	SG079		6	6	6
76	measuring tape, paper	SK048		1	1	1
77	electrode skin prep gel (NuPrep)	SJ022		100	100	100
78	povidone soln (Betadine)	SJ041		1	10	1
79	sensor strip, skin temperature	SJ045		1	1	1
80	**Equipment**					
81	table, exam	EF023		24	30	24
82	hydrocollator, hot	EQ130		24		24
83	EMG-NCV-EP system 8 channel	EQ024		24	30	24
85						
86						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Codes Reported Together 75% or More
Different Performing Specialty from Survey

April 2012

Autonomic Function Testing

CPT codes 95921 and 95922 were identified through the Codes Reported Together 75% or More screen as well as the Different Performing Specialty from the Survey screen. In February 2012, the CPT Editorial Panel created a new code 95924 which combines the procedures currently described in 95921 and 95922 as these are currently reported together more than 75% of the time. Additionally, the dominant specialties now performing these services are Family Medicine and Internal Medicine, specialties that were not part of the 1996 survey. Lastly, the utilization for 95921 and 95922 has dramatically increased and from 2008 to 2009 and continue to rise, which the specialties attribute to incorrect reporting of these services for the use of a device for an automated nervous system test. Therefore, the CPT Editorial Panel created CPT 95943 to describe the automated nervous system test, in which providers do not use a tilt table during autonomic testing.

95921 Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio
The RUC reviewed the survey results from 33 neurologists, neuromuscular and electrodiagnostic medicine physicians and determined that the current work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC agreed with the median survey results of 8 minutes pre-service time, 15 minutes intra-service time and 10 minute immediate post-service time. The specialties indicated and the RUC agreed that the key reference service 95925 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs* (work RVU = 0.54) is not an appropriate comparison for this service because the physician is not present during the test, it is much less intense and there is very little risk compared 95921 in which the physician is present and patients are fainting and have arrhythmias. The RUC compared the surveyed code to MPC codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93 and 15 minutes intra-service time) and determined that these services required similar physician work and the same intra-service time to perform. For additional support, the RUC compared the surveyed code to the secondary key reference service 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08 and 15 minutes intra-service time) and determined 95921 requires slightly less physician work to perform and MPC code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75 and 20 minutes total time) and determined that 95921 requires more physician work and time to perform. **The RUC recommends a work RVU of 0.90 for CPT code 95921.**

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95922 Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt
The specialty societies indicated that 20 minutes of tilt is the new standard to perform this service; abnormalities may go undetected in less time. However, depending on the specific conditions of the patient the tilt table time may be less than 20 minutes. The RUC indicated that once physicians are practicing the new standard for this service and 20 minutes of tilt table is typical, at their discretion, the specialties may go to CPT to change the descriptor to "at least 20 minutes".

The RUC reviewed the survey results from neurologists, neuromuscular and electrodiagnostic medicine physicians and determined that the current work RVU of 0.96 appropriately accounts for the work required to perform this service. The RUC agreed with the median survey results of 10 minutes pre-service time, 20 minutes intra-service time and 10 minute immediate post-service time. The RUC compared the surveyed code to MPC codes 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20 and 20 minutes intra-service time) and determined that 95805 services requires slightly more physician work to perform. For additional support, the RUC compared the surveyed code to MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time) and determined that 95922 requires similar physician work to perform. **The RUC recommends a work RVU of 0.96 for CPT code 95922.**

95924 Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt
The specialty societies indicated that 20 minutes of tilt is the new standard to perform this service; abnormalities may go undetected in less time. However, depending on the specific conditions of the patient the tilt table time may be less than 20 minutes. The RUC indicated that once physicians are practicing the new standard for this service and 20 minutes of tilt table is typical, at their discretion, the specialties may go to CPT to change the descriptor to "at least 20 minutes".

The specialty societies indicated that 95924 combines the services currently described in 95921 and 95922. The typical patient that will receive the combined tests 95924 is more complex and the testing is more intense than the patient that will just have one test (95921 or 95922). The RUC reviewed the survey results for 95924 and determined that the survey response rate was too low (26 responses). There was also confusion about what is described in 95943 which may have resulted in invalid physician time for this service. As an interim recommendation, the RUC recommends that the physician work and intra-service time for 95921 and 95922 be added together to account for the physician work and time required to perform this service (0.90 + 0.96 = 1.86 and 15 minutes + 20 minutes = 35 minutes intra-service time). The RUC recommends interim pre-service time of 10 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. **The RUC recommends an interim work RVU of 1.86 for CPT code 95924 until this service is resurveyed for the October 2012 RUC meeting.**

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95923 Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential
The RUC reviewed the survey results from neurologists, neuromuscular and electrodiagnostic medicine physicians and determined that the current work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC agreed with the survey 5 minutes pre-service time, 15 minutes intra-service time and 10 minute immediate post-service time, which are the current times. The RUC compared the surveyed code to key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time) and determined that 95923 requires similar physician work and intensity and complexity to perform. The RUC also compared 95923 to 95921 and determined that the physician work and intra-service time is the same for these services. **The RUC recommends a work RVU of 0.90 for CPT code 95923.**

95943 Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change
The American College of Physicians will survey 95943 once the physicians that use this "small box" technology are identified and matched as members of these societies in order to survey. AMA staff will also provide Medicare claims data by state to the specialty societies to indicate that 40% of the volume for code 95921 is from Florida and Texas. This code is scheduled for the October 2012 RUC meeting.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

The purpose of autonomic nervous system function testing is to determine the presence of autonomic dysfunction, the site of autonomic dysfunction, and the various autonomic subsystems that may be disordered.

Code 95921 should be reported only when electrocardiographic monitoring of heart rate derived from the time elapsing between two consecutive R waves in the electrocardiogram, or the R-R interval, is displayed on a monitor and stored for subsequent analysis of waveforms. Testing is typically performed in the prone position. A tilt table may be used, but is not required equipment for testing of the parasympathetic function. At least two of the following components need to be included in testing:

1. Heart rate response to deep breathing derived from a visual quantitative analysis of recordings with subject breathing at a rate of 5-6 breaths per minute.
2. Valsalva ratio determined by dividing the maximum heart rate by the lowest heart rate. The initial heart rate responses to sustained oral pressure (blowing into a tube with an open glottis) consist of tachycardia followed by a bradycardia at 15-45 seconds after the Valsalva pressure has been released. A minimum of two Valsalva maneuvers are to be performed.The initial cardioacceleration is an exercise reflex while the subsequent tachycardia and bradycardia are baroreflex-mediated.
3. A 30:15 ratio (R-R interval at beat 30)/(R-R interval at beat 15) used as an index of cardiovascular function

Code 95922 should be reported only when all of the following components are included in testing:

1. Continuous recording of beat-to-beat BP and heart rate.The heart rate needs to be derived from an electrocardiogram (ECG) unit such that an accurate quantitative graphical measurement of the R-R interval is obtained;
2. A period of supine rest of at least 20 minutes prior to testing;
3. The performance and recording of beat-to-beat blood pressure and heart rate during a minimum of two (2) Valsalva maneuvers;
4. The performance of passive head-up tilt with continuous recording of beat-to-beat blood pressure and heart rate for a minimum of five minutes, followed by passive tilt-back to the supine position. This must be performed using a tilt table.

Code 95924 should be reported only when both the parasympathetic function and the adrerenergic function are tested together with the use of a tilt table.

(To report autonomic function testing that does not include beat to beat recording or for testing without use of a tilt table, use 95943)

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95921	BB1	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	XXX	0.90 (No Change)
95922	BB2	vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt (Do not report 95922 in conjunction with 95921)	XXX	0.96
●95924	BB3	combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt (Do not report 95924 in conjunction with 95921 or 95922)	XXX	1.86 (Interim) (Resurvey for October 2012 RUC Meeting)
95923	BB4	sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	XXX	0.90 (No Change)

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●95943	BB5	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change (Do not report 95943 in conjunction with 93040, 95921, 95922, 95924)	XXX	Specialty Societies Requests Postponement to October 2012 RUC Meeting

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American Association of Neuromuscular & Electrodiagnostic Medicine
2621 Superior Drive NW, Rochester, MN 55901 T: 507.288.0100 F: 507.288.1225 www.aanem.org

March 14, 2012

Ms. Sherry Smith, Director
Physician Payment Policy and Systems
American Medical Association
151 North State Street
Chicago, IL 60654

RE: RUC Survey of proposed CPT Code 95922X
Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function

This letter is to inform you that based on appeals to members, including work with the maker of the product, the AANEM is unable to identify a statistically valid sub-set of our members who perform the above service. Under these circumstances, we do not feel that we can provide meaningful input into a RUC survey for this newly created code.

It is our understanding that our colleagues at the American College of Physicians will continue to work with its members to prepare a summary of recommendations to be presented at the October 2012 RUC meeting.

Please feel free to contact our office if you have any questions.

Sincerely,

Catherine French

Catherine French
AANEM Director of Health Policy

Cc: Debra Lansey, ACP

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95921 Tracking Number BB1 Original Specialty Recommended RVU: **0.90**
Presented Recommended RVU: **0.90**
Global Period: XXX RUC Recommended RVU: **0.90**

CPT Descriptor: Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient who has diabetes and numbness of her feet presents because of frequent lightheadedness which is interfering with her ability to function normally. The general exam is unremarkable. Testing of the autonomic nervous system, specifically the parasympathetic function, is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work: Pre-service work includes review of the patient's records regarding the indication for the test and the clinical question. A tilt table may be used to perform this test.

Description of Intra-Service Work: Intra-service work involves supervision of patient preparation and performance of the test by the technician. Electrocardiographic monitoring of heart rate is derived from R-R interval displayed on a monitor and stored for analysis. Heart response to deep breathing is derived from an analysis of recordings with subject breathing at a rate of 5-6 breaths per minute. Valsalva ratio is determined by dividing the maximum heart rate by the lowest heart rate. The initial heart rate responses to standing consist of tachycardia at 3 and then 12-15 seconds followed by a bradycardia at 20 seconds. The initial cardioacceleration is an exercise reflex while the subsequent tachycardia and bradycardia are baroreflex-medicated. The 30:15 ratio (R-R interval at beat 30)/(R-R interval at beat 15) is used as an index of cardiovascular function. The results of these measures are reviewed, data is interpreted, and a clinical correlation of the findings is done based on the patient's history.

Description of Post-Service Work: Post-service work includes generating, reviewing, and signing the study report based on the findings of the tests. Findings are discussed with the referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Kevin Kerber, MD (AAN); Andrea Boon, MD (AANEM)				
Specialty(s):	AAN, AANEM				
CPT Code:	95921				
Sample Size:	127	**Resp N:**	33	**Response:** 25.7 %	
Description of Sample:	Random - members who indicated they perform the services				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	50.00	**100.00**	150.00	800.00
Survey RVW:	0.50	0.86	**1.00**	1.88	6.00
Pre-Service Evaluation Time:			**8.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	75.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95921	**Recommended Physician Work RVU: 0.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**8.00**	**0.00**	**8.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95925	XXX	0.54	**RUC Time**

CPT Descriptor Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	152,826

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	3,074,347

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 21.21 **%**

TIME ESTIMATES (Median)	**CPT Code: 95921**	**Key Reference CPT Code:** 95925	**Source of Time** RUC Time
Median Pre-Service Time	8.00	6.50	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**33.00**	**31.50**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.86	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.86
Urgency of medical decision making	2.14	2.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.71	3.86
Physical effort required	2.29	2.14
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.14
Outcome depends on the skill and judgment of physician	3.29	3.29
Estimated risk of malpractice suit with poor outcome	1.86	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.29	2.29
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.43	2.43

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Autonomic Function Testing family includes 5 services. Two new services were created, and three existing services were surveyed as part of the family. The Relativity Assessment Workgroup and the CPT Editorial Panel requested

creation of a combined code for those times when both types of autonomic function are performed together (95921 and 95922 = 9592XX) and to ensure those providers who do not use tilt table during automatic testing report an appropriate code (95922X). Existing service 95923 was also surveyed as part of the family.

Much of the current utilization for 95921 and 95922 will shift to the new codes 9592XX and 95922X. The specialty mix will also change, with Neurology and Cardiology being the dominant providers. Data that shows an E/M billed on the same day reflect the improper usage of these codes. An E/M service typically would not be billed on the same day.

While 76% of respondents found the vignette to be typical, there are many indications for this service, which account for the remaining respondents who did not find it typical.

The key reference service was 95925, which has similar times and a much lower RVW. The societies recommend that the current RVW of 0.90 be maintained.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95921

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 68612
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty Neurology Frequency 27445 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,153 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Much of the utilization for this code will shift to new codes 9592XX and 95922X.

Specialty Neurology Frequency 6862 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95923

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95922 Tracking Number BB2 Original Specialty Recommended RVU: **1.10**
Presented Recommended RVU: **1.10**
Global Period: XXX RUC Recommended RVU: **0.96**

CPT Descriptor: Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt
(Do not report 95922 in conjunction with 95921)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient has frequent syncopal episodes which have impaired his ability to function normally. Prolonged tilt study confirmed syncope and a diagnosis of neurocardiogenic syncope was made, but treatment for this did not result in meaningful improvement. Because of this, testing of his autonomic nervous system, specifically of the vasomotor adrenergic innervation, is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Pre-service work includes review of the patient's records regarding the indication for the test and the clinical question.

Description of Intra-Service Work: Intra-service work includes supervision of patient preparation and performance of the test by the technician. Continuous beat-to-beat recording of blood pressure and heart rate in response to the Valsalva maneuver is performed. Patient is positioned on tilt table and after period of rest, undergoes at least five minutes of passive tilt-up and tilt-back. A series of Valsalva maneuvers are performed until reproducible arterial responses are obtained. The results of these measures are reviewed, data is interpreted, and a clinical correlation of the findings is done based on the patient's history.

Description of Post-Service Work: Post-service work includes generating, reviewing, and signing the study report based on the findings of the tests. Findings are discussed with the referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Kevin Kerber, MD (AAN); Andrea Boon, MD (AANEM)		
Specialty(s):	AAN, AANEM		
CPT Code:	95922		
Sample Size:	127	**Resp N:** 29	**Response:** 22.8 %
Description of Sample:	Random - members who indicated they perform the services		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	12.00	90.00	**110.00**	180.00	800.00
Survey RVW:	0.50	1.08	**1.50**	2.45	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**20.00**	30.00	75.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95922	**Recommended Physician Work RVU: 0.96**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95805	XXX	1.20	**RUC Time**

CPT Descriptor Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36510	000	1.09	**Harvard Time**	5

CPT Descriptor 1 Catheterization of umbilical vein for diagnosis or therapy, newborn

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
56605	000	1.10	**RUC Time**	27,933

CPT Descriptor 2 Biopsy of vulva or perineum (separate procedure); 1 lesion

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 17.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 95922**	**Key Reference CPT Code:** 95805	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	15.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**40.00**	**50.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.40
Urgency of medical decision making	3.20	2.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	3.40
Physical effort required	2.80	2.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	2.60
Outcome depends on the skill and judgment of physician	4.00	3.60
Estimated risk of malpractice suit with poor outcome	2.40	2.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	3.00
Intra-Service intensity/complexity	3.80	3.20
Post-Service intensity/complexity	3.00	2.80

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The existing RVW of 0.96 is based on a 1996 RUC survey. The expert panel believes that this code meets the compelling evidence standards for an increased RVW. There have been changes in physician work due to:

- Technique
- Change in patient population
- Physician time

Since the inception of tilt table testing, the patients tested have gradually shifted from a preponderance of orthostatic hypotension (requiring a 5 minute tilt) to postural tachycardia syndrome (requiring a 20 minute tilt) who now dominate the referral reason for tilt by about 3 to 1. In addition indeterminate dizziness is a frequent referral symptom which may require 30 minutes, or until that symptom is reproduced. The physician must be in the room during the upright period of time for patient safety. Finally, even the diagnosis of orthostatic hypotension itself has evolved. The paper by Gibbons and Freeman clearly demonstrates the presence of a clinically significant new diagnosis of delayed orthostatic hypotension that may be associated with syncope and falls. This diagnosis also requires 30 to 40 minutes of tilt (see attachment). Thus, a real change in the population and in our approach to the diagnosis has increased the intensiveness of 95922. This has been a gradual change and all respondents may not have been aware of the new standard of care. There is often a lag between what is published in the literature and when most practices catch up to it. Patients being evaluated for Postural Orthostatic Tachycardia Syndrome will remain in upright tilt for typically 20 minutes. Patients being evaluated for delayed Orthostatic Hypotension will remain in upright tilt for 30 minutes.

CPT	Descriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	XXX	1.10	10	30	10	50	0.0217

Although the RVW would increase 15%, the Medicare utilization for this code is expected to drop dramatically, from about 67,000 to about 1,343.

The key reference service of 95805 has the same total time but less intra time and a higher RVW at 1.20. Respondents rated code 95922 with higher complexity and intensity than the reference service in all measures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95922

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5372
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national utilization at 4 times the Medicare rate.

Specialty Neurology Frequency 2149 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,343
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Much of the utilization for this code will shift to new codes 9592XX and 95922X.

Specialty Neurology Frequency 538 Percentage 40.05 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95923

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95924 Tracking Number BB3 Original Specialty Recommended RVU: **1.89**
Presented Recommended RVU: **1.89**
Global Period: XXX RUC Recommended RVU: **1.86**

CPT Descriptor: Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt
(Do not report 9592XX in conjunction with 95921 or 95922)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with repeated, unexplained episodes of fainting. Tests of cardiovascular function indicate severe cardiovagal impairment. Testing of the autonomic nervous system, specifically of parasympathetic function and vasomotor adrenergic function using a 5-minute tilt with a passive tilt table, is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 80.77%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Pre-service work includes review of the patient's records regarding the indication for the test and the clinical question.

Description of Intra-Service Work: Intra-service work includes supervision of patient preparation and performance of the test by the technician. The patient lays on a tilt table in a flat position. The patient is connected to an EKG machine and electrodes are attached to the chest, legs and arms. If needed, an IV line is placed in the arm. A blood pressure (BP) monitor and the heart rate (HR) and BP are constantly monitored during the procedure.
Blood pressure and heart rate are monitored while lying still. Deep breathing and a series of Valsalva maneuvers are performed until reproducible arterial responses are obtained. Electrocardiographic monitoring of heart rate derived from R-R interval is displayed on a monitor and stored for analysis. Heart response to deep breathing is derived from an analysis of recordings with subject breathing at a rate of 5-6 breaths per minute. This is a measure of cardiovagal or parasympathetic testing. Continuous beat-to-beat recording of blood pressure and heart rate in response to the Valsalva maneuver are captured and at least five minutes of passive tilt-up and tilt-back are performed. A series of Valsalva maneuvers are performed until reproducible arterial responses are obtained. These blood pressure responses are analyzed in order to assess cardiac and vascular adrenergic function. Valsalva ratio is determined by dividing the maximum heart rate by the lowest heart rate. This is another measure of cardiovagal or parasympathetic function. The initial heart rate responses to standing consist of tachycardia at 3 and then 12-15 seconds followed by a bradycardia at 20 seconds. The initial cardioacceleration is an exercise reflex while the subsequent tachycardia and bradycardia are baroreflex-medicated. The 30:15 ratio (R-R interval at beat 30)/(R-R interval at beat 15) is used as index of cardiovascular function. The physician reviews and analyzes this data.

After obtaining a baseline HR and BP, safety straps are applied across the chest and legs to hold the patient in place. The patient is raised to the upright and lowered to the supine position several times. The duration of time spent in the supine and upright position can vary from 5 to 30 minutes. Medication may be administered and adjusted during the testing to increase the heart rate and blood pressure. After completing the test, the patient remains flat or supine until the HR and BP return to normal. The patient is observed for 10 to 20 minutes and then disconnected from the equipment.
The results of these measures are reviewed, data is interpreted, and a clinical correlation of the findings is done based on the patient's history.

Description of Post-Service Work: Post-service work includes generating, reviewing, and signing the study report based on the findings of the tests. Findings are discussed with the referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Kevin Kerber, MD (AAN); Andrea Boon, MD (AANEM)				
Specialty(s):	AAN, AANEM				
CPT Code:	95924				
Sample Size:	125	**Resp N:**	26	**Response:** 20.8 %	
Description of Sample:	Random - members who indicated they perform the services				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	27.50	**100.00**	150.00	800.00
Survey RVW:	0.70	1.43	**1.89**	2.50	5.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	17.50	**26.00**	47.50	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95924	**Recommended Physician Work RVU: 1.86**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99244	XXX	3.02	**Harvard Time**

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90806	XXX	1.86	**CMS Time File**	6,270,188

CPT Descriptor 1 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99385	XXX	1.92	**RUC Time**	

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 23.08 **%**

TIME ESTIMATES (Median)	**CPT Code: 95924**	**Key Reference CPT Code:** 99244	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	35.00	40.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**60.00**	**65.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	4.33
Urgency of medical decision making	4.33	4.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.83	3.17
Physical effort required	4.17	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.17	3.50
Outcome depends on the skill and judgment of physician	4.17	4.17
Estimated risk of malpractice suit with poor outcome	3.83	3.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.83	2.83
Intra-Service intensity/complexity	4.67	4.17
Post-Service intensity/complexity	4.00	3.50

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The expert panel reviewed the survey times and determined some respondents must have been confused about what the new code describes. This service involves the work of 95921 and 95922 and the intra-service time should be 45 minutes, the combined intra-service times for 95921 (15 minutes) and 95922 (30 minutes). The intra-service work of providing the two tests does not decrease by providing them on the same day, and it is more complicated to interpret the two tests together than individually. There is an economy of 10 minutes saved in pre-time and 5 minutes saved in post-time.
The expert panel recommends 10/45/15 minutes and the median RVW of 1.89. The key reference service (99244) has similar times (10/40/15) but a higher RVW at 3.02. Respondents ranked 95924 with higher or the same intensity and complexity as the reference service in 10 of 11 measures.
These existing codes serve as crosswalks with comparable times and RVWs:

CPT	Descriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes	XXX	1.90	10	50	10	70	0.0290
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	000	1.89	15	50	15	80	0.0244

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95921 and 95922

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Neurology Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 64,581 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We analyzed the times that 95921 and 95922 were reported together. Of that total, approximalely 30% will go to this code. (70% will go to code 95922X)

Specialty Neurology Frequency 25833 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95923

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95923 Tracking Number BB4 Original Specialty Recommended RVU: **0.90**
Presented Recommended RVU: **0.90**
Global Period: XXX RUC Recommended RVU: **0.90**

CPT Descriptor: Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient develops severe burning sensation affecting his toes and proximal foot. Standard laboratory tests are unremarkable. On exam, there is no compelling sensory loss and normal reflexes. The electromyogram and nerve conduction studies are within normal limits. Testing of the autonomic nervous system, specifically sudomotor function, is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 96.30%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Pre-service work includes review of the patient's records regarding the indication for the test and the clinical question.

Description of Intra-Service Work: Intra-service work includes supervision of patient preparation and performance of the test by the technician. Sympathetic nerve fibers to the sweat glands are stimulated at standard sites by the iontophoresis of acetylcholine and the evoked sweat response is measured by sudometers. Optimally the test is performed on one forearm site and three lower extremity sites in order to determine the severity and distribution of the sympathetic deficit. Thermoregulatory sweat test is a test of sympathetic nerves that supply the skin and involves dusting the skin with an indicator powder which changes color when the patient sweats in response to raising patient's temperature in a heat cabinet. Sympathetic skin potentials are evoked through electrical stimulation of the skin and recordings are made over the palm and soles of the feet. The skin potential change is carried by autonomic nerve fibers and determines if these fibers are working normally. The results of these measures are reviewed, data is interpreted, and a clinical correlation of the findings is done based on the patient's history.

Description of Post-Service Work: Post-service work includes generating, reviewing, and signing the study report based on the findings of the tests. Findings are discussed with the referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Kevin Kerber, MD (AAN); Andrea Boon, MD (AANEM)		
Specialty(s):	AAN, AANEM		
CPT Code:	95923		
Sample Size:	124	**Resp N:** 27	**Response:** 21.7 %
Description of Sample:	Random - members who indicated they perform the services		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	72.50	**100.00**	182.50	1000.00
Survey RVW:	0.55	0.91	**1.03**	1.30	2.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	23.75	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	95923	**Recommended Physician Work RVU: 0.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	152,826

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	3,074,347

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 95923**	**Key Reference CPT Code:** 99213	**Source of Time**
			RUC Time
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	5.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.50
Urgency of medical decision making	3.50	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	3.00
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.83	2.83
Outcome depends on the skill and judgment of physician	3.83	3.67
Estimated risk of malpractice suit with poor outcome	3.00	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	2.83
Intra-Service intensity/complexity	3.50	3.00
Post-Service intensity/complexity	3.33	3.17

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The expert panel reviewed the survey results and recommends maintaining the RVW (0.90). This RVW falls below the 25th percentile on the survey. The service has not changed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95923

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 22104
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate national usage at 4 times the Medicare rate.

Specialty Neurology Frequency 18568 Percentage 84.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,526
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare utilization from RUC database

Specialty Neurology Frequency 4642 Percentage 84.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95923

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Autonomic Function Testing

TAB: 34

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-EVAL	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	7	0.011			0.54			31.5	6.5			15			10
RUC	95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio		0.030			0.90			35	10			15			10
SVY	95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	33	0.040	0.50	0.86	1.00	1.88	6.00	33	8	5	10	15	20	75	10
REC	95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart		0.033			0.90			33	8			15			10
MPC	20551	Injection(s); single tendon origin/insertion		0.083			0.75			20	10			5			5
MPC	99202	Office or other outpatient visit for the evaluation and management of a new patient, which		0.052			0.93			22	2			15			5

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	O	P	Q	R	S	T
24						RVW					Total	PRE-	INTRA-TIME					IMMD
25	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
26	REF	95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	5	0.026			1.20			50	15			20			15
27	RUC	95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt		0.020			0.96			45	10			25			10
28	SVY	95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	29	0.053	0.50	1.08	1.50	2.45	4.00	40	10	5	10	20	30	75	10
29	REC	95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt		0.026			0.96			40	10			20			10
30	MPC	36510	Catheterization of umbilical vein for diagnosis or therapy, newborn		0.030			1.09			42	12			20			10
31	MPC	56605	Biopsy of vulva or perineum (separate procedure); 1 lesion		0.043			1.10			35	10			15			10
32	Crosswalk	95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)		0.022			1.10			50	10			30			10

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	O	P	Q	R	S	T
33																		
34						RVW					Total	PRE-	INTRA-TIME					IMMD
35	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
36	REF	99244	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.	6	0.062			3.02			65	10			40			15
37	CURRENT	n/a			#DIV/0!						0							
38	SVY	95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	26	0.051	0.70	1.43	1.89	2.50	5.00	51	10	10	20	26	45	120	15
39	REC	95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt		0.037			1.86			60	10			35			15
40	MPC	90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or		0.037			1.86			50				50			
41	MPC	99385	Initial comprehensive preventive medicine evaluation and management of an individual		0.053			1.92			45	5			30			10
42	Crosswalk	90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with		0.029			1.90			70	10			50			10
43	Crosswalk	93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring,		0.024			1.89			80	15			50			15
44																		

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	O	P	Q	R	S	T
45						RVW					Total	PRE-	INTRA-TIME					IMMD
46	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST
47	REF	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate	6	0.053			0.97			23	3			15			5
48	RUC	95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential		0.030			0.90			35	10			15			10
49	SVY	95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	27	0.048	0.55	0.91	1.03	1.30	2.50	29.5	5	5	10	15	23	45	10
50	REC	95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential		0.038			0.90			30	5			15			10
51	MPC	20551	Injection(s); single tendon origin/insertion		0.083			0.75			20	10			5			5
52	MPC	99202	Office or other outpatient visit for the evaluation and management of a new patient, which		0.052			0.93			22	2			15			5

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: **Testing of autonomic nervous system function; cardiovagal innvervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breating with recorded R-R internal, Valsalva ratio, and 30:15 ratio**

Global Period: XXX Meeting Date: April, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The societies convened a consensus panel of physicians to develop recommended inputs. The physicians on the panel represent a variety of geographic locations and practice settings.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The comparison code for 95921, is the existing codes (with RUC-approved inputs from 2000-2001).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technician explains the procedure and asks detailed questions on medications, previous surgeries and other exclusions that may alter the outcome of testing. Patient is encouraged to empty bladder before testing begins.

The technician assists the patient in lying on the exam table and answers any questions the patient may have. An arm and finger blood pressure cuff is attached.

Service Clinical Labor Activities:

The technician instructs the patient in baseline breathing and coaches the patient through deep breathing maneuvers, giving feedback on the number of seconds left in each maneuver.
If needed, balloon monitoring effort during inhalation and expiration is also provided by the technician.

Multiple Valsalva tests are performed –lying flat and from a mild tilt position. The patient rests between each maneuver.

The technician works to ensure the patient understands and complies with test specific instructions during the entirety of testing and assesses the patient for any reactions during testing, including blood pressure response to the Valsalva maneuver.

Post-Service Clinical Labor Activities:

The technician obtains resting blood pressure reading and removes arm and finger cuff, If a patient needs additional recuperation time, the technician stays with the patient, monitoring vital signs and assisting the patient with ambulating back to the dressing room.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: **Testing of autonomic nervous system function; vasomotor adrenergic innveration (sympathetic adrenergic function), including beat-to-beat blood pressure and RR interval changes during Valsalva maneuver and at least 5 minutes of passive tilt.**

Global Period: XXX Meeting Date: April, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The societies convened a consensus panel of physicians to develop recommended inputs. The physicians on the panel represent a variety of geographic locations and practice settings.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The comparison code for 95922 is the existing codes (with RUC-approved inputs from 2000-2001).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technician explains the procedure and asks detailed questions on medications, previous surgeries and other exclusions that may alter the outcome of testing. Patient is gowned if clothing is too restrictive for adequate access to sites necessary for testing. Patient is encouraged to empty bladder before testing begins.

The technician assists the patient in lying on the exam table and answers any questions the patient may have. ECG electrodes are placed, blood pressure and finger cuffs are administered and a respiratory monitoring belt is attached to the patient.

Service Clinical Labor Activities:

The technician instructs the patient in baseline breathing and coaches the patient through multiple sets of deep breathing maneuvers, giving feedback on the number of seconds left in each maneuver. The patient is allowed to rest for 2 minutes between each set of breathing maneuvers.

Multiple Valsalva tests are performed –lying flat and from a mild tilt position. The patient rests between each maneuver. The patient then rests for 5 minutes before being placed in full heads up tilt position. Prior to tilt testing, the technician records the blood pressure and acquires baseline blood pressure

readings to compare to system readings. During tilt testing, the technician monitors heart rate and blood pressure and observes the patient for any adverse effects.

The technician works to ensure the patient understands and complies with test specific instructions during the entirety of testing and assesses the patient for any reactions during testing, including blood pressure response to the Valsalva maneuver.

Post-Service Clinical Labor Activities:

The patient is allowed to rest for several minutes post testing. The technician obtains multiple (maximum of 8 minutes) resting blood pressure readings and removes arm and finger cuff, electrodes, respiratory belts and any additional monitoring equipment. If a patient needs additional recuperation time, the technician stays with the patient, monitoring vital signs and assisting the patient with ambulating back to the dressing room.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: **Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt**

Global Period: XXX Meeting Date: April, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The societies convened a consensus panel of physicians to develop recommended inputs. The physicians on the panel represent a variety of geographic locations and practice settings.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The comparison codes for 9592XX are 95921 and 95922, because the new code is a combination of those two codes provided on the same day.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technician explains the procedure and asks detailed questions on medications, previous surgeries and other exclusions that may alter the outcome of testing.

The technician assists the patient in lying on the exam table and answers any questions the patient may have. ECG electrodes are placed, blood pressure and finger cuffs are administered and a respiratory monitoring belt is attached to the patient.

Service Clinical Labor Activities:

The technician instructs the patient in baseline breathing and coaches the patient through deep breathing maneuvers, giving feedback on the number of seconds left in each maneuver.

The technician works to ensure the patient understands and complies with test specific instructions during the entirety of testing and assesses the patient for any reactions during testing, including blood pressure response to the Valsalva maneuver.

Prior to tilt testing, the technician records the blood pressure and acquires 10 minutes of baseline blood pressure readings. During tilt testing, the technician monitors heart rate and blood pressure and observes the patient for any adverse effects.

Post-Service Clinical Labor Activities:

The technician obtains multiple resting blood pressure readings and removes arm and finger cuff, electrodes, respiratory belts and any additional monitoring equipment. If a patient needs additional recuperation time, the technician stays with the patient, monitoring vital signs and assisting the patient with ambulating back to the dressing room.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: **Testing of autonomic nervous system function; sudomotor, including 1 or more of the following quantitative sudomotor axon reflex tests (QSART), silastic sweat imprinting (SIT), thermoregulatory sweat test (TST), and changes in sympathetic skin potential.**

Global Period: XXX Meeting Date: April, 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The societies convened a consensus panel of physicians to develop recommended inputs. The physicians on the panel represent a variety of geographic locations and practice settings.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: The comparison code for 95923 is the existing codes (with RUC-approved inputs from 2000-2001).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technician explains the procedure and asks detailed questions on medications, previous surgeries and other exclusions that may alter the outcome of testing. Patient is encouraged to empty bladder before testing begins.

The technician assists the patient in lying on the exam table and answers any questions the patient may have.

For QSART testing: the patient may need to be gowned if clothing restricts access to skin. The technician assembles 4 capsules used for stimulation and recording and cleans multiple recording sites on the patient's arms, leg and foot. The capsules are secured and stimulation grounds and wires are attached. Surface skin temperature is verified. Warmers may be used at capsule site to ensure adequate skin temperature. The tech verifies the patient can feel a stimulus.

For SIT testing: electrodes are placed on the hands and feet

For TST testing: Vital signs (weight, height, temperature) are recorded. The patient is gowned and the technician assembles and secures capsules used for recording.

Service Clinical Labor Activities:

For QSART testing: The technician fills the capsules with a mixture of acetylcholine and water. The technician starts the recordings, verifying there are no leaks in the capsules and that the baseline recording is stable. Stimulation is begun, and the technician review latency and volume throughout the procedures. Once stimulation is complete, the nerves are monitored during a short period of rest.

For SIT testing: The technician stimulates sweat glands and applies a thin layer of moldable silastic material to the skin.

For TST: The technician and patient apply faces mask during powder application. The technician applies powder to the patient's entire body and places a thermal probe on the skin and in the patient's mouth. The patient is assisted into the heat box and observed throughout the testing for increased body temperature or sweat production. Probes are also used to control the heat lamps in the box.

Post-Service Clinical Labor Activities:

For all three tests: Capsules are removed and patient is monitored to ensure vital signs are normal.

For SIT testing: the number of droplets, size and distribution are reported

For TST: The patient is removed from the box at a rate slow enough to ensure the body has time to adjust to temperature changes. Photos are taken, computer scanning performed to map the areas of increased sweat production. Patient's weight is recorded. After the majority of powder is brushed off the patient, the technician assists the patient to the shower and provides additional instructions to ensure the powder is washed off safely.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**REVISED**				**REFERENCE CODE**				**REFERENCE CODE**						**REFERENCE CODE**		
2				**95921**		**95921**		**95922**		**95922**		**95924**		**95923**		**95923**	
3	**Meeting Date: April 2012** **Tab: 33** **Specialty: AAN, AANEM**	**CMS Code**	**Staff Type**	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing		Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during		Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint,		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**64.0**	**0.0**	**64.0**	**0.0**	**92.0**	**0.0**	**79.0**	**0.0**	**79.0**	**0.0**	**81.0**	**0.0**	**74.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**10.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**49.0**	**0.0**	**64.0**	**0.0**	**77.0**	**0.0**	**79.0**	**0.0**	**79.0**	**0.0**	**66.0**	**0.0**	**74.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**5.0**	**0.0**	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**																
11	**Start: Following visit when decision for surgery or procedure made**																
12	Complete pre-service diagnostic & referral forms																
13	Coordinate pre-surgery services																
14	Schedule space and equipment in facility					**0**				**0**		**0**				**0**	
15	Provide pre-service education/obtain consent																
16	Follow-up phone calls & prescriptions																
17	Other Clinical Activity - *specify:*																
18	**End: When patient enters office/facility for surgery/procedure**																
19	**SERVICE PERIOD**																
20	**Start: When patient enters office/facility for surgery/procedure:**																
21	Greet patient, provide gowning, ensure appropriate medical records are available	**L037A**	**Electrodiagnos**			**3**				**3**		**3**				**3**	
22	Obtain vital signs					**3**				**3**		**3**				**3**	
23	Provide pre-service education/obtain consent	**L037A**	**Electrodiagnos**			**3**				**3**		**3**				**3**	
24	Prepare room, equipment, supplies	**L037A**	**Electrodiagnos**			**2**				**2**		**2**				**2**	
25	Setup scope (non facility setting only)																
26	Prepare and position patient/ monitor patient/ set up IV																
27	Sedate/apply anesthesia																
28	**Intra-service**																
29	perform test	**L037A**	**Electrodiagnos**			**45**				**60**		**60**				**55**	
30	**Post-Service**																
31	Monitor pt. following service/check tubes, monitors, drains	**L037A**	**Electrodiagnos**			**5**				**5**		**5**				**5**	
32	Clean room/equipment by physician staff	**L037A**	**Electrodiagnos**			**3**				**3**		**3**				**3**	
33	Clean Scope																
34	Clean Surgical Instrument Package																
35	Complete diagnostic forms, lab & X-ray requisitions																
36	Review/read X-ray, lab, and pathology reports																
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions																
38	Other Clinical Activity - *specify:*																
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**																
43	**POST-SERVICE Period**																
44	**Start: Patient leaves office/facility**																
45	Conduct phone calls/call in prescriptions																
53	Other Clinical Activity - *specify:*																
54	**End: with last office visit before end of global period**																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**REVISED**				**REFERENCE CODE**				**REFERENCE CODE**						**REFERENCE CODE**		
2				**95921**		**95921**		**95922**		**95922**		**95924**		**95923**		**95923**	
3	**Meeting Date: April 2012** **Tab: 33** **Specialty: AAN, AANEM**	**CMS Code**	**Staff Type**	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing		Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during		Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint,		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**														
56	pack, minimum multi-specialty visit	SA048	pack			1				1		1				1	
57	gown, patient	SB026	item	1		0		1		0		0		1		0	
58	electrode, ECG (single)	SD053	item	4		6		4		6		6		4			
59	gauze, sterile 4in x 4in	SG055	item	2		2		2		2		2		2		2	
60	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	6		0		6		0		0		6		0	
61	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1		1		1		1		1	
62	mouthpiece, respiratory	SD099	item	1		1		0		1		1		0		1	
63	gloves, non-sterile	SB022	pair	2		0		2		0		0		2		0	
64	paper, exam table	SB036	foot	7		0		7		0		0		7		0	
65	electrode conductive gel	SJ020	ml	5		5		5		5		5		5		5	
66	swab-pad, alcohol	SJ053	item	2		2		2		2		2		2		2	
67	tape, surgical paper 1in (Micropore)	SG079	inch	6		6		6		6		6		6		6	
68	acetylcholine (for patient use)	SH002	gm											50		50	
69	kit, electrode, iontophoresis	SA014														4	
70	eye shield, non-fog	SG049	item													2	
71	indicator powder*		gram													10	
72	**EQUIPMENT**	**CODE**															
73	arterial tonometry acquisition system (WR Testworks)	EQ051		30		64		40		79		79		0			
74	table, tilt (w-trendelenberg)	EF032		30		64		40		79		79		0			
75	arterial tonometry monitor (Colin Pilot)	EQ052				64		40		79		79		0			
76	light, infra-red, ceiling mount	EQ171						40		0		0		45		74	
77	QSART acquisition system (Q-Sweat)	EQ035												45		74	
78	stimulator, constant current, w-stimulating and grounding electrodes (Grass Telefactor)	EQ124												45		74	
79																	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**REVISED**				**REFERENCE CODE**				**REFERENCE CODE**						**REFERENCE CODE**		
2				**95921**		**95921**		**95922**		**95922**		**95924**		**95923**		**95923**	
3	**Meeting Date: April 2012** **Tab: 33** **Specialty: AAN, AANEM**	**CMS Code**	**Staff Type**	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing		Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during		Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint,		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**64.0**	**0.0**	**55.0**	**0.0**	**92.0**	**0.0**	**70.0**	**0.0**	**76.0**	**0.0**	**81.0**	**0.0**	**61.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**10.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**49.0**	**0.0**	**55.0**	**0.0**	**77.0**	**0.0**	**70.0**	**0.0**	**76.0**	**0.0**	**66.0**	**0.0**	**61.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037A**	**Electrodiagnos**	**5.0**	**0.0**	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**																
11	**Start: Following visit when decision for surgery or procedure made**																
12	Complete pre-service diagnostic & referral forms																
13	Coordinate pre-surgery services																
14	Schedule space and equipment in facility					**0**				**0**		**0**				**0**	
15	Provide pre-service education/obtain consent																
16	Follow-up phone calls & prescriptions																
17	Other Clinical Activity - *specify:*																
18	**End: When patient enters office/facility for surgery/procedure**																
19	**SERVICE PERIOD**																
20	**Start: When patient enters office/facility for surgery/procedure:**																
21	Greet patient, provide gowning, ensure appropriate medical records are available	**L037A**	**Electrodiagnos**			**0**				**0**		**3**				**3**	
22	Obtain vital signs					**0**				**0**		**3**				**3**	
23	Provide pre-service education/obtain consent	**L037A**	**Electrodiagnos**			**3**				**3**		**3**				**3**	
24	Prepare room, equipment, supplies	**L037A**	**Electrodiagnos**			**2**				**2**		**2**				**2**	
25	Setup scope (non facility setting only)																
26	Prepare and position patient/ monitor patient/ set up IV																
27	Sedate/apply anesthesia																
28	**Intra-service**																
29	perform test	**L037A**	**Electrodiagnos**			**45**				**60**		**60**				**45**	
30	**Post-Service**																
31	Monitor pt. following service/check tubes, monitors, drains	**L037A**	**Electrodiagnos**			**2**				**2**		**2**				**2**	
32	Clean room/equipment by physician staff	**L037A**	**Electrodiagnos**			**3**				**3**		**3**				**3**	
33	Clean Scope																
34	Clean Surgical Instrument Package																
35	Complete diagnostic forms, lab & X-ray requisitions																
36	Review/read X-ray, lab, and pathology reports																
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions																
38	Other Clinical Activity - *specify:*																
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**																
43	**POST-SERVICE Period**																
44	**Start: Patient leaves office/facility**																
45	Conduct phone calls/call in prescriptions																
53	Other Clinical Activity - *specify:*																
54	**End: with last office visit before end of global period**																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**REVISED**				**REFERENCE CODE**				**REFERENCE CODE**						**REFERENCE CODE**		
2				**95921**		**95921**		**95922**		**95922**		**95924**		**95923**		**95923**	
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4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**														
56	pack, minimum multi-specialty visit	SA048	pack			1				1		1				1	
57	gown, patient	SB026	item	1		0		1		0		0		1		0	
58	electrode, ECG (single)	SD053	item	4		6		4		6		6		4			
59	gauze, sterile 4in x 4in	SG055	item	2		2		2		2		2		2		2	
60	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	6		0		6		0		0		6		0	
61	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1		1		1		1		1	
62	mouthpiece, respiratory	SD099	item	1		1		0		1		1		0		1	
63	gloves, non-sterile	SB022	pair	2		0		2		0		0		2		0	
64	paper, exam table	SB036	foot	7		0		7		0		0		7		0	
65	electrode conductive gel	SJ020	ml	5		5		5		5		5		5		0	
66	swab-pad, alcohol	SJ053	item	2		2		2		2		2		2		2	
67	tape, surgical paper 1in (Micropore)	SG079	inch	6		6		6		6		6		6		6	
68	acetylcholine (for patient use)	SH002	gm											50		50	
69	kit, electrode, iontophoresis	SA014														4	
70	eye shield, non-fog	SG049	item													2	
71	indicator powder*		gram													10	
72	**EQUIPMENT**	**CODE**															
73	arterial tonometry acquisition system (WR Testworks)	EQ051		30		55		40		70		76		0			
74	table, tilt (w-trendelenberg)	EF032		30		55		40		70		76		0			
75	arterial tonometry monitor (Colin Pilot)	EQ052				55		40		70		76		0			
76	light, infra-red, ceiling mount	EQ171						40		0		0		45		61	
77	QSART acquisition system (Q-Sweat)	EQ035												45		61	
78	stimulator, constant current, w-stimulating and grounding electrodes (Grass Telefactor)	EQ124												45		61	
79																	

AMA/Specialty Society RVS Update RUC Summary of Recommendations

January 2012

Intraoperative Neurophysiology Monitoring

The CPT Editorial Panel deleted CPT code 95920 *Intraoperative neurophysiology testing, per hour* and created two new add-on codes to describe continuous intraoperative neurophysiology monitoring in the operating room and remotely due to new technology available to perform these services.

95940 ***Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes***

The RUC reviewed the survey results for code 95940 and determined that the survey respondents overestimated the physician work required to perform this service, incorrectly accounting for the entire monitoring encounter not basing their response on the time increment indicated in the descriptor. Therefore, the RUC compared the 95940 to 64566 *Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming* (work RVU = 0.60 and total time = 15 minutes) and determined these services required the same physician work, time and intensity to perform. The RUC also compared 95940 to similar services 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes* (work RVU = 0.55) and 97814 *Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)* (work RVU = 0.55) and determined that these services are less intense than 95940. **The RUC recommends a work RVU of 0.60 and 15 minutes intra-service time for CPT code 95940.**

95941 ***Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour***

The RUC reviewed the survey results for code 95941 and determined that the survey respondents overestimated the physician work required to perform this service. Therefore, the RUC compared the 95941 to 31627 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation* (work RVU = 2.00 and intra-time = 60 minutes) and determined these services required the same physician work, time and intensity to perform. For additional support the RUC also compared 95941 to similar services 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (work RVU = 1.98 and intra-time = 60 minutes) and determined that these services require similar physician work and the same amount of time to perform.

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The RUC noted some concern that this service may be reported for monitoring a number of patients simultaneously. The specialty society indicated that they included a question on the survey asking the typical number of patients monitored by the physician and respondents indicated that one patient is typically being monitored by the physician. Additionally, the RUC reviewed the range of add-on services with intra-service time ranging from 50-70 minutes, with work RVUs ranging from 1.00 to 5.00, and agreed that this 60 minute code at 2.00 work RVUs reported for multiple patients is in the appropriate physician work range relative to other similar services in the RBRVS. **The RUC recommends a work RVU of 2.00 for CPT code 95941.**

Practice Expense
The RUC noted that although CPT code 95941 is performed in the non-facility approximately 5% of the time, direct practice expense inputs for medical supplies and equipment were accepted as modified by the Practice Expense Subcommittee.

New Technology/New Services
The RUC recommends that these services be reviewed in three years to review the number of times this service is reported together by the same physician on the same day once this utilization data is available.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
Medicine **Neurology and Neuromuscular Procedures** **Intraoperative Neurophysiology** Codes 95940, 95941 describe ongoing neurophysiologic monitoring, testing and data interpretation distinct from performance of specific type(s) of baseline neurophysiologic study(s) performed during surgical procedures. When the service is performed by the surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologist's primary service code(s) for the procedure and are not reported separately. Do not report these codes for automated monitoring devices that do not require continuous attendance by a professional qualified to interpret the testing and monitoring. Recording and testing ~~is~~ are performed either personally or by a technologist who is physically present with the patient during the service. Supervision is performed either in the operating room or by real time connection outside the operating room. The monitoring professional must be solely dedicated to performing the **intraoperative neurophysiologic** monitoring and must be available to intervene at all times during the service as necessary, for the reported time period(s). For any given period of time spent providing these services, the service takes full attention and, therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period of time. Throughout the monitoring, there must be provisions for continuous and immediate communication directly with the operating room team in the surgical suite. One or more simultaneous cases may be reported **(95941).** When monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual's exclusive attention be required for another procedure. Report 95941 for all **remote or non-one on one** monitoring time connected to each case regardless of overlap with other cases ~~(95941).~~ Codes 95940, 95941 include only the ongoing neurophysiologic monitoring time distinct from performance of specific type(s) of baseline neurophysiologic study(s) ~~(51785 (needle EMG urethral sphincter)~~, 95860-95870 (needle EMG's), 95900-95904 (nerve conduction), 95928 , 95929 (central motor evoked potential), 95933-95937, 95961, 95962 (cortical and subcortical mapping) or interpretation of specific type(s) of baseline neurophysiologic study(s) (92585, 95822, 95925~~,~~95930). For 95940 and 95941, the baseline neurophysiologic study(s) should be reported not more than once per operative session. The time spent performing or interpreting the baseline neurophysiologic study(s) should not be counted as intraoperative monitoring, but represents separately reportable procedures. For procedures that last beyond midnight, report services using the day on which the monitoring began and using the total time monitored. Code 95940 is reported per 15 minutes of service. Code 95940 requires reporting only the portion of ~~the~~ time the monitoring professional was physically present in the operating room providing one-on-one patient monitoring, and no other cases may be monitored at the same time. Report continuous intraoperative neurophysiologic monitoring in the operating room (95940) in addition to the services related to monitoring from outside the operating room (95941).					

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Code 95941 should be used once per hour even if multiple methods of neurophysiologic monitoring are used during the time. Code 95941 requires the monitoring of neurophysiological data that is collected from the operating room continuously on-line in real time via a secure data link. When reporting 95941, real-time ability must be available through sufficient data bandwidth transfer rates to view and interrogate the neurophysiologic data contemporaneously.

Report 95941 for all cases in which there was no physical presence by the monitoring professional in the operating room during the monitoring time **or when monitoring more than one case in an operating room.** It is also used to report the time of monitoring physically performed outside of the operating room in those cases where monitoring occurred both within and outside the operating room. Do not report 95941 if the monitoring lasts 30 minutes or less.

Intraoperative neurophysiology monitoring codes 95940 and 95941 are each used to report the total duration of respective time spent ~~**by a physician**~~ providing each service, even if that time is not in a single continuous block.

D +95920		~~Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure~~ ~~(Use 95920 in conjunction with the study performed, 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925 95937)~~ (95920 has been deleted. To report, see 95940, 95941) ~~(Code 95920 describes ongoing electrophysiologic testing and monitoring performed during surgical procedures. Code 95920 is reported per hour of service, and includes only the ongoing electrophysiologic monitoring time distinct from performance of specific type[s] of baseline electrophysiologic study[s] [95860, 95861, 95867, 95868, 95870, 95900, 95904, 95928, 95929, 95933 95937] or interpretation of specific type[s] of baseline electrophysiologic study[s] [92585, 95822, 95870, 95925- 95928, 95929, 95930]. The time spent performing or interpreting the baseline electrophysiologic study[s] should not be counted as intraoperative monitoring, but represents separately reportable procedures. Code 95920 should be used once per hour even if multiple electrophysiologic studies are performed. Do not report 95920 if recording lasts 30 minutes or less. The baseline electrophysiologic study[s] should be used once per operative session. For procedures that last beyond midnight, report services using the day on which the monitoring began and using the total hours monitored)~~	ZZZ	N/A

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●✚95940	P1	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure) (Use 95940 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939)	ZZZ	0.60
●✚95941	P2	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure) (Use 95941 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939) (For time spent waiting on standby before monitoring, use 99360) (For electrocorticography, use 95829) (For intraoperative EEG during nonintracranial surgery, use 95955) (For intraoperative functional cortical or subcortical mapping, see 95961-95962) (For intraoperative neurostimulator programming and analysis, see 95970-95975)	ZZZ	2.00

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95940 Tracking Number P1 Original Specialty Recommended RVU: **0.72**
Presented Recommended RVU: **0.60**
Global Period: ZZZ RUC Recommended RVU: **0.60**

CPT Descriptor: Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
(Use 959X1 in conjunction with the study performed, 92585, 95822, 95860-95870, 95900-95904, 95925-95937)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old woman has new onset of seizures and MRI evidence of a mass in the right frontal lobe consistent with a glioma. A decision was made to resect the tumor. Intraoperative neurophysiologic testing and monitoring was ordered to avoid damaging or resecting motor pathways during surgery.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 1%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician (or other qualified health care provider) changes into operating room clothing and reviews medical records and imaging.

Description of Intra-Service Work: The physician personally performs the intraoperative monitoring or testing process during one or more aspects of the procedure, and provides a diagnostic interpretation of these neurophysiologic tests in real time during the surgery. Data collection typically is from multiple data channels of electromyography (EMG), electroencephalography (EEG), or evoked potentials (EPs). Data are compared to a baseline diagnostic test recorded immediately prior to when the monitoring began. Data are reviewed on several screen displays either simultaneously or sequentially. This in-room service involves personal investigation and resolution of technical issues that may compromise the monitoring. The provider personally consults with the surgeon or anesthesiologist about the neurophysiologic status and the clinical implications as appropriate throughout the procedure. To accomplish this, the provider compares responses over time, actively tests structures to assess the integrity (i.e., measures resopnses to electric stimulations of the extremities or brain), and interprets the findings in order to localize abnormalities and assess the potential implications. This information is communicated directly to the surgeon and anesthesiologist and adjustments in the procedure are recommended as necessary. The impact of adjustments are then monitored and communicated. Ongoing neurophysiologic diagnostic testing procedures typically involve averaging hundreds or thousands of individual trials of microvolt or nanovolt data collection in 16-32 channels, which are measured in millisecond or microsecond accuracies.

Description of Post-Service Work: The physician changes out of operating room clothing and prepares a report for the portions of the procedure performed during the intraoperative monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Marianna Spanaki, MD, PhD (AAN); Benn Smith, MD (AANEM); Marc Nuwer, MD, PhD (ACNS); Joe Zuhosky, MD (AAPMR)		
Specialty(s):	AAA, AAN, ACNS, AANEM, AAPMR, ASHA		
CPT Code:	95940		
Sample Size:	218	**Resp N:** 64	**Response:** 29.3 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**20.00**	75.00	1000.00
Survey RVW:	0.50	2.05	**3.00**	3.83	6.20
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	42.50	**120.00**	240.00	480.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	95940	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95954	XXX	2.45	**RUC Time**

CPT Descriptor Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92012	XXX	0.92	**RUC Time**	6,806,813

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
99245	XXX	3.77	**RUC Time**

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 23.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 95940**	**Key Reference CPT Code:** 95954	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	15.00	60.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**70.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.07
Urgency of medical decision making	4.80	4.07
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	4.27
Physical effort required	3.20	2.87
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	4.00
Outcome depends on the skill and judgment of physician	4.60	4.40
Estimated risk of malpractice suit with poor outcome	3.80	3.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	3.20
Intra-Service intensity/complexity	4.67	4.27
Post-Service intensity/complexity	2.73	2.87

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 6 surveying specialties met via conference call and email to develop recommendations. The societies believe the survey respondents gave time data according to the entire time (median of 2 hours) they are in the operating room for the case, rather than the increments of 15 minutes that the code describes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached table.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95920

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty Audiology How often? Rarely

Specialty PM&R How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 14936
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national rate at 4 times the Medicare frequency.

Specialty Neurology Frequency 4929 Percentage 33.00 %

Specialty Audiology Frequency 1942 Percentage 13.00 %

Specialty PM&R Frequency 2988 Percentage 20.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,734
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We looked at 2010 Medicare utilization for 95920 and estimate a very small (2.5%) percentage would be reported as 959X1.

Specialty Neurology	Frequency 1233	Percentage 33.02 %
Specialty Audiology	Frequency 0	Percentage 0.00 %
Specialty PM&R	Frequency 747	Percentage 20.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95920

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95941 Tracking Number P1 Original Specialty Recommended RVU: **2.09**
Presented Recommended RVU: **2.00**
Global Period: ZZZ RUC Recommended RVU: **2.00**

CPT Descriptor: Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)
(Use 95941 in conjunction with the study performed 92585, 95822, 95860-95870, 95900-95904, 95925-95937)
(For time spent waiting on standby before monitoring, use 99360)
(For electrocorticography, use 95829)
(For intraoperative EEG during nonintracranial surgery, use 95955)
(For intraoperative functional cortical or subcortical mapping, see 95961-95962)
(For intraoperative neurostimulator programming and analysis, see 95970-95975)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old man complains of three months of leg weakness and two episodes of falling. Neurologic exam showed increased lower extremity reflexes, an upgoing right toe, and mildly decreased lower extremity sensation. Imaging showed cervical spondylosis producing severe spinal canal stenosis and cervical myelopathy. Surgery was scheduled for spinal cord decompression with cervical anterior and posterior instrumentation. Intraoperative neurophysiologic monitoring was ordered to monitor spinal cord integrity during the procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: The physician (or other qualified health care provider) provides an interpretation of diagnostic neurophysiologic tests in real time during the surgery. The interpretations are made by viewing tracings on a remote computer screen similar to the screen used by the technologist in the operating room. Data collection typically is from 16-32 data channels of electromyography (EMG), electroencephalography (EEG), or evoked potentials (EPs). Data are compared to baseline EMG, EEG, or EPs recorded just prior to the intraoperative monitoring. This patient's data are reviewed typically on 4-8 different screen displays that can be viewed either simultaneously or sequentially. The physician supervises the direct electrical scalp stimulation of 200-600 volts with precautions to prevent injury or seizures. The physician screens for and identifies changes that occur during surgery and determining if they present a risk of clinical harm, as opposed to changes due to other causes. When investigating causes of change, the physician applies knowledge of the patient's medical history and physical findings, imaging findings, anesthetic changes, technical details of the testing,

and what the surgeon is doing. The physician then arrives quickly at a diagnostic assessment of risk, severity, and location. The physician informs the surgeon and anesthesiologist of the risk. The physician may recommend clinical changes in anesthetic or surgical techniques to reduce risk of neurologic injury. The physician then measures the adequacy of response to interventions. To make these determinations the physician supervises performance of and provides diagnostic interpretations of the ongoing results of neurophysiologic testing procedures. This typically involves averaging hundreds or thousands of individual trials of microvolt or nanovolt data collection in 16-32 channels, which are measured to millisecond or microsecond accuracies.

Description of Post-Service Work: Prepare a report of the diagnostic interpretations made during surgery.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Marianna Spanaki, MD, PhD (AAN); Benn Smith, MD (AANEM); Marc Nuwer, MD, PhD (ACNS); Joe Zuhosky, MD (AAPMR)		
Specialty(s):	AAA, AAN, ACNS, AANEM, AAPMR, ASHA		
CPT Code:	95941		
Sample Size:	217	**Resp N:** 66	**Response:** 30.4 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	60.00	**214.00**	700.00	3000.00
Survey RVW:	0.20	2.09	**2.50**	3.16	7.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	60.00	**180.00**	240.00	720.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	95941	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99292	ZZZ	2.25	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	21,952,122

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	2.50	**RUC Time**	311,700

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU	Time Source
95813	XXX	1.73	**RUC Time**

CPT Descriptor Electroencephalogram (EEG) extended monitoring; greater than 1 hour

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 18.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 95941**	**Key Reference CPT Code:** 99292	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**60.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.08	4.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	4.50
Urgency of medical decision making	4.75	4.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.42	4.17
Physical effort required	3.92	4.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.67	4.67
Outcome depends on the skill and judgment of physician	4.83	4.75
Estimated risk of malpractice suit with poor outcome	4.58	4.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.75	3.83
Intra-Service intensity/complexity	4.50	4.58
Post-Service intensity/complexity	3.58	3.92

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel representing members of each of the 6 surveying specialties met via conference call and email to develop recommendations. The consensus panel recommends the 25th percentile values for time and RVW – 60 minutes and 2.09 RVW.
The post-service involves an additional OR report on the changes and responses during the course of surgery.

Below are ZZZ Global codes, with less than 5.00 work RVUs and intra-time between 52 and 68 minutes.

CPT Code	Work RVU	Pre	Intra	Post	Total	Global	Source
99356	1.71		60		60	ZZZ	RUC
99354	1.77		60		60	ZZZ	RUC
95941	2.00		60		60	ZZZ	RUC-Recommended
31627	2.00		60		60	ZZZ	RUC
19126	2.93		60		60	ZZZ	RUC
17314	3.06	8	60		68	ZZZ	RUC
17312	3.30	8	65		73	ZZZ	RUC
95967	3.49		60		60	ZZZ	RUC
63621	4.00		60		60	ZZZ	RUC
34808	4.12		60		60	ZZZ	RUC
92981	4.16		60		60	ZZZ	RUC
22522	4.30		50		50	ZZZ	RUC
44121	4.44		60		60	ZZZ	RUC
44203	4.44		60		60	ZZZ	RUC
61864	4.49		68		68	ZZZ	RUC
34813	4.79		60		60	ZZZ	RUC
38102	4.79		60		60	ZZZ	RUC
61799	4.81		60		60	ZZZ	RUC
63103	4.82		60		60	ZZZ	RUC
38747	4.88		60		60	ZZZ	RUC
49568	4.88		52		52	ZZZ	RUC
37186	4.92		60		60	ZZZ	RUC

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached table.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95920

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty Audiology How often? Rarely

Specialty PM&R How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 582548
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national rate at 4 times the Medicare frequency.

Specialty Neurology Frequency 192241 Percentage 33.00 %

Specialty Audiology Frequency 79200 Percentage 13.59 %

Specialty PM&R Frequency 116510 Percentage 20.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 145,637 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We looked at 2010 Medicare utilization for 95920 and estimate the vast majority (97.5%) would be reported as 95941.

Specialty Neurology Frequency 48061 Percentage 33.00 %

Specialty Audiology Frequency 0 Percentage 0.00 %

Specialty PM&R Frequency 29128 Percentage 20.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95920

SS Rec Summary

ISSUE: Intraoperative Neurophysiology Monitoring

TAB: 12

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	95954	EEG monitoring/giving drugs	15	0.037			2.45			70	5					60			5
CURRENT	95920	IOM, per hour		n/a			2.11			49									
SVY	95940	IOM in the OR, 1 on 1, each 15 min		0.017	0.50	2.05	3.00	3.83	6.20	165	30			10	43	120	240	480	15
REC	95940	IOM in the OR, 1 on 1, each 15 min		0.046			0.72			17			1			15			1
MPC	92012	Eye exam established pat		0.046			0.92			25	5					15			5
MPC	77300	Radiation therapy dose plan		0.041			0.62			15	0					15			0

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	99292	Critical care addl 30 min	12	0.075			2.25			30						30			
REF	95813	EEG over 1 hour	12	0.035			1.73			60	15					30			15
CURRENT	95920	IOM, per hour		n/a			2.11			49									
SVY	95941	IOM outside OR or >1 in OR, per hour		0.010			2.50			210	15					180			15
REC	95941	IOM outside OR or >1 in OR, per hour		0.034			2.09			62						60			2
MPC	95810	Polysomnography 4 or more		0.050			2.50			66.5	15					37			15
MPC	99233	Subsequent hospital care		0.048			2.00			55	10					30			15

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)

95941 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)

Global Period: **ZZZ** Meeting Date: **January 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The societies convened a consensus panel of physicians to develop recommended inputs. The physicians on the panel represent a variety of geographic locations and practice settings.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:
We included existing code 95920 as a reference code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **n/a**

Intra-Service Clinical Labor Activities: **n/a**

Post-Service Clinical Labor Activities: **n/a**

	A	B	C	D	E	F	G
2				95940		95941	
3	**Meeting Date: January 2012** **Specialty: AAA, AAN, AANEM, AAPMR, ACNS, ASHA**	**CMS**	**Staff**	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance,		Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the	
4	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**		**ZZZ**	
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
21	Greet patient, provide gowning, ensure appropriate medical records are available						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure			0		0	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management						
39	Other Clinical Activity (please specify)						
40	**End: Patient leaves office**						
41	**POST-SERVICE Period**						
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions						
53	Other Activity (please specify)						
54	**End: with last office visit before end of global period**				**0**		0
55	**MEDICAL SUPPLIES**		**Unit**				
56	Communications, wireless	SK113	1	0		20	
57							
58	**Equipment**						
59	Cart	ES003		0		20	
60	IONM software*	EQ013		0		20	
61	Server	ED022		0		20	
62							
63							

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2012

Neonatal Pediatric Transport

In October 2011, the CPT Editorial Panel created CPT codes 99485 and 99486 to describe the non face-to-face services provided by physicians to supervise interfacilty transport care of critically ill or critically injured pediatric patients.

99485 *Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes*

CPT code 99485 was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 84 neonatologists, pediatric intensivists, pediatric emergency physicians and pediatric transport medicine physicians and noted that the survey median work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC was concerned that the total service time was 7 minutes more than the key reference service CPT code 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility); 15-29 minutes* (work RVU = 1.25). It was clarified that CPT code 99339 requires 40 minutes total time and 99485 requires 47 because the typical patients are critically ill or critically injured as opposed to the key reference code, which are not. The intra-service time of the code is the same as the key reference code, however it was clarified that due to the unique severity in the conditions of this subset of patients there is more planning and preparation required by the control physician in the pre-service and more documentation that the control physician must complete in the post-service, which accounts for an additional 5 minutes in the pre-service and 2 minutes in the post-service time as compared to the key reference code.

The RUC also discussed assigning 47 minutes to a code that is stated as 30 minutes in the descriptor. The CPT Editorial Panel representative clarified that according to CPT guidelines, code 99485 is used to report the first 16-45 minutes of direction on a given date and should only be used once even if time spent by the physician is discontinuous. Do not report services of 15 minutes or less or any time when another physician is reporting 99466-99467. Coding instructions only apply once the intra-service has begun and does not include pre- and post-service time. Once the 46th minute is reached the second code 99486 (add-on) should be reported. To further justify the survey median work RVU of 1.50, the RUC reviewed CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU=1.42), because this also has a intra-service time of 20 minutes and although it is face-to-face, the typical patient is less critical. Only a small portion of the pediatric transports (estimated at less than 10%) should report code 99485 because it only applies to the most complex patients. **The RUC recommends a work RVU of 1.50 for CPT code 99485**.

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99486 *Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes*

CPT code 99486 was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 71 neonatologists, pediatric intensivists, pediatric emergency physicians, pediatric transport medicine physicians and recommends the survey median work RVU of 1.30. The specialty society indicated and the RUC agreed that 25 minutes intra-service time appropriately accounts for the physician time required to perform this service. The specialty society explained that the intra-service time for 99486 is higher than the intra-service time for the base code 99485, 25 and 20 minutes respectively, because in order to report both codes more than 45 minutes of intra-service time is required (30 minutes threshold required to report 99485 and greater than 15 minutes threshold required to report 99486). If you add the intra-service time for 99485 (20 minutes) and the intra-service time for 99486 (25 minutes), that 45 minutes total intra-service time is achieved. The RUC determined that this time differential is appropriate. The RUC compared 99486 to key reference service 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility); 30 minutes or more* (work RVU = 1.80, 30 minutes intra-service time, 60 minutes total time) and determined that although the typical patient for 99486 is critically ill or critically injured, the key reference service requires more physician work and time and should be valued higher. The RUC compared 99486 to the key MPC reference code 13102 *Repair, complex, trunk; each additional 5 cm or less* (work RVU=1.24, 25 minutes intra-service time) and determined that both codes are ZZZ globals, have the same intra-service time and should be valued similarly. Only a small portion of the pediatric transports (estimated at less than 10%) should report code 99486 because it only applies to the most complex patients. **The RUC recommends a work RVU of 1.30 for CPT code 99486**.

CPT Editorial Panel:
During discussion of the new neonatal pediatric transport codes 99485, 99486, the RUC noted that there may be overlap in reporting of the existing critical care interfacility transport codes 99466 or 99467. The RUC recommended that either the Neonatal Pediatric Transport guidelines or a parenthetical instruction be added following codes 99485 and 99486 to instruct users that it is not appropriate to report codes 99485 and 99486 in addition to codes 99466 and 99467 by the same physician. The following language was added as a parenthetical instruction: (Do not report 99485 or 99486 in conjunction with 99466, 99467 when performed by the same physician).

Practice Expense:

This service is primarily performed in a facility, so there are no direct practice expense inputs associated with this service.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Evaluation and Management** **Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services** **Pediatric Critical Care Transport**				
Codes (99466, 99467) are used to report the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger. Codes 99485, 99486 are used to report the control physician non-face-to-face supervision of interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger. These codes are not reported together for the same patient by the same physician. For the purpose of reporting ~~codes~~ 99466 and 99467, face-to-face care begins when the physician assumes primary responsibility of the pediatric patient at the referring ~~hospital/~~facility, and ends when the receiving ~~hospital/~~facility accepts responsibility for the pediatric patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported. Pediatric patient transport services involving less than 30 minutes of face-to-face physician care should not be reported using 99466, 99467. Procedure(s) or service(s) performed by other members of the transporting team may not be reported by the supervising physician. Codes 99485, 99486 are used to report control physician non-face-to-face supervision of interfacility pediatric critical care transport, which includes all two way communication between the control physician and the specialized transport team prior to transport, at the referring facility and during transport of the patient back to the receiving facility. The "control" physician is the physician directing transport services. These codes do not include pre-transport communication between the control physician and the referring facility before or following patient transport. These codes are only reported for patients 24 months or younger who are critically ill or critically injured. The control physician provides treatment advice to a specialized transport team ~~of providers~~ who are present and delivering the hands-on patient care.				

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The control physician does not report any services provided by the specialized transport team. The control physician's non-face-to-face time begins with the first contact by the control physician with the specialized transport team and ends when the patient's care is handed over to the receiving facility team. ~~These codes do not include face-to-face hands on transport care by the supervising physician.~~ Time spent with the individual patient's transport team and reviewing data submissions should be recorded. Refer to 99466 and 99467 for face-to-face transport care of the critically ill/injured patient. Time spent with the individual patient's transport team and reviewing data submissions should be recorded. Code 99485 is used to report the first 16-45 minutes of direction on a given date and should only be used once even if time spent by the physician is discontinuous. Do not report services of 15 minutes or less or any time when another physician is reporting 99466-99467. (Do not report 99485 or 99486 in conjunction with 99466, 99467 when performed by the same control physician)

For the definition of the critically injured …

The non face to face direction of emergency care to a patient's transporting staff by a physician located in a hospital or other facility by two-way communication is not considered direct face-to-face care and should not be reported with 99466, 99467. Physician-directed non face to face emergency care through outside voice communication to transporting staff personnel is reported with 99288 or 99466, 99467 based upon the age and clinical condition of the patient.

Emergency department services …

~~The following~~ All non face to face transport supervision services (99288, 99485, 99486) are included when performed in conjunction with the services reported with 99466 and 99467, ~~during the pediatric patient transport by the physician providing critical care~~ and may not be reported separately: ~~routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry), the interpretation of cardiac output measurements (93562), chest X-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases and information data stored in computers (eg, ECGs, blood pressures, hematologic data) (99090), gastric intubation (43752, 43753), temporary transcutaneous pacing (92953), ventilatory management (94002, 94003, 94660, 94662) and vascular access procedures (36000, 36400, 36405, 36406, 36415, 36591, 36600). Any services performed which are not listed above should be reported separately. All services of the control physician during time reported are included in 99485, 99486.~~ Services provided by the specialized transport team during non-face-to-face transport supervision are not reported by the control physician.

Code 99466 is used to report …

Code 99485 is used to report the first 30 minutes of non-face-to-face supervision of an interfacility transport of a critically ill or critically injured pediatric patient and should be reported only once per date of service. Code 99486 is used to report each additional 30 minutes beyond the initial 30 minutes. Non-face-to-face interfacility transport ~~less than~~ 15 minutes or less is not reported.

(For total body cooling of neonates, see 0260T, 0261T)

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99466		Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport	XXX	4.79 (No Change)
+ 99467		each additional 30 minutes (List separately in addition to code for primary service)	ZZZ	2.40 (No Change)
#●99485	Q1	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes	XXX	1.50
#+●99486	Q2	each additional 30 minutes (List separately in addition to code for primary procedure) (Use 99486 in conjunction with 99485) (For physician direction of emergency medical systems supervision for a pediatric patient over 24 months of age, or at any age if not critically ill or injured, use 99288) (Do not report 99485, 99486 with any other services reported by the control physician for the same period) (Do not report 99485 or 99486 in conjunction with 99466-99467 when performed by the same physician)	ZZZ	1.30

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99485 Tracking Number Q1 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: XXX RUC Recommended RVU: **1.50**

CPT Descriptor: Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-week critically ill or critically injured neonate is delivered at a level I hospital and the community provider requests a transfer to the physician's hospital. The ground transport team consisting of a nurse and respiratory therapist is dispatched to the level I hospital. After the team evaluates the patient, they contact the control physician to discuss the case. The physician and team remain in two-way communication and decide together on the appropriate management and interventions for the child before and during transport back to the control physician's hospital.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The transport control physician receives a report on a request to transport a critically ill pediatric patient and determines with the specialized transport team the appropriate form of transportation, the urgency of the transport, the appropriate mode of transport, the type of team members needed to meet the patient's needs, and any required special equipment or medications.

Description of Intra-Service Work: The transport control physician discusses the planned patient treatment with the specialized transport team before and after leaving the initial facility where care is provided and continues to be in contact with the specialized transport team during the transport to the receiving facility. The control physician maintains two-way communication availability to the transport team throughout the transport.

Description of Post-Service Work: The transport control physician documents the total contact time with the specialized transport team and summarizes the consultative advice provided to the specialized transport team before and during patient transport.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Steve Krug, MD, Gil Martin, MD, and Dan Brown, MD, PhD				
Specialty(s):	American Academy of Pediatrics (AAP) and Society of Critical Care Medicine (SCCM)				
CPT Code:	99485				
Sample Size:	1419	**Resp N:**	84	**Response:** 5.9 %	
Sample Type:	Panel **Additional Sample Information:** Surveyees included AAP and SCCM members who perform this service (eg, neonatologists, pediatric intensivists, pediatric emergency physicians, pediatric transport medicine physicians)				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	7.50	**20.00**	42.50	700.00
Survey RVW:	0.75	1.22	**1.50**	2.00	7.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	14.25	**20.00**	30.00	120.00

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	99485	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99339	XXX	1.25	**RUC Time**

CPT Descriptor Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99238	XXX	1.28	**RUC Time**	5,061,578

CPT Descriptor 1 Hospital discharge day management; 30 minutes or less

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
99340	XXX	1.80	**RUC Time**

CPT Descriptor Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 22.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 99485**	**Key Reference CPT Code:** 99339	**Source of Time RUC Time**
Median Pre-Service Time	15.00	10.00	

Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	12.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**47.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.38	3.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.74	3.63
Urgency of medical decision making	4.60	3.36
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.70	2.55
Physical effort required	2.24	2.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.42	3.38
Outcome depends on the skill and judgment of physician	4.37	3.52
Estimated risk of malpractice suit with poor outcome	4.32	3.35

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.44	3.04
Intra-Service intensity/complexity	4.14	3.69
Post-Service intensity/complexity	3.25	2.92

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A joint AAP-SCCM expert panel reviewed the survey results and given the quality of the data, recommended the survey medians. This recommendation is further substantiated by the fact that patients cared for under code 99485 are critically ill/critically injured, while they are not under the key reference service (99339).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Transport supervision of a critically ill or injured pediatric patient will typically be reported in conjunction with NICU/PICU critical care service codes.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global Period	Pre-Service	Intra-Service	Post-Service	Total Time
4.	9948X1	XXX	15	20	12	47
5.	9948X2	ZZZ	0	25	0	25
6.	99471	XXX	30	180	30	240
7.	99472	ZZZ	20	90	30	140

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99288

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Critical Care Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 9000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. According to the latest information (June 2010) provided by the American Academy of Pediatrics Section on Transport Medicine, there are at least 80,430 yearly transports reported on the Neonatal/Pediatric Transport Team Database, with approximately 10% of those requiring medical oversight.

Specialty Pediatrics Frequency 4500 Percentage 50.00 %

Specialty Critical Care Frequency 4500 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Critical Care Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99471

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99486 Tracking Number Q2 Original Specialty Recommended RVU: **1.30**
Presented Recommended RVU: **1.30**
Global Period: ZZZ RUC Recommended RVU: **1.30**

CPT Descriptor: Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-week critically ill or critically injured neonate is delivered at a level I hospital and the community provider requests a transfer to the physician's hospital. The ground transport team consisting of a nurse and respiratory therapist is dispatched to the level I hospital. After the team evaluates the patient, they contact the control physician to discuss the case. The physician and team remain in two-way communication and decide together on the appropriate management and interventions for the child before and during transport back to the control physician's hospital. 9948X1 has been reported and 9948X2 is reported for each additional 30 minutes. This is an add-on code.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 49%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 13%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The transport control physician discusses the planned patient treatment with the specialized transport team before and after leaving the initial facility where care is provided and continues to be in contact with the specialized transport team during the transport to the receiving facility. The control physician maintains two-way communication availability to the transport team throughout the transport.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Steve Krug, MD, Gil Martin, MD, and Dan Brown, MD, PhD				
Specialty(s):	American Academy of Pediatrics (AAP) and Society of Critical Care Medicine (SCCM)				
CPT Code:	99486				
Sample Size:	1419	**Resp N:** 71	**Response:** 5.0 %		
Sample Type:	Panel **Additional Sample Information:** Surveyees included AAP and SCCM members who perform this service (eg, neonatologists, pediatric intensivists, pediatric emergency physicians, pediatric transport medicine physicians)				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.50	**10.00**	30.00	700.00
Survey RVW:	0.50	0.93	**1.30**	1.80	6.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**25.00**	30.00	40.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	99486	**Recommended Physician Work RVU: 1.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99340	XXX	1.80	**RUC Time**

CPT Descriptor Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	15,986

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
99339	XXX	1.25	**RUC Time**

CPT Descriptor Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 32.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 99486**	**Key Reference CPT Code:** 99340	**Source of Time RUC Time**
Median Pre-Service Time	0.00	15.00	

Median Intra-Service Time	25.00	30.00
Median Immediate Post-service Time	0.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**25.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.34	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	3.41
Urgency of medical decision making	4.48	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.68	2.46
Physical effort required	2.14	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.48	3.31
Outcome depends on the skill and judgment of physician	4.38	3.41
Estimated risk of malpractice suit with poor outcome	4.24	3.31

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.78
Intra-Service intensity/complexity	4.02	3.43
Post-Service intensity/complexity	2.95	2.86

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A joint AAP-SCCM expert panel reviewed the survey results and given the quality of the data, recommended the survey medians. This recommendation is further substantiated by the fact that patients cared for under code 99486 are critically ill/critically injured, while they are not under the key reference service (99340).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Transport supervision of a critically ill or injured pediatric patient will typically be reported in conjunction with NICU/PICU critical care service codes.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global Period	Pre-Service	Intra-Service	Post-Service	Total Time
4.	9948X1	XXX	15	20	12	47
5.	9948X2	ZZZ	0	25	0	25
6.	99471	XXX	30	180	30	240
7.	99472	ZZZ	20	90	30	140

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99288

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Critical Care Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. According to the latest information (June 2010) provided by the American Academy of Pediatrics Section on Transport Medicine, there are at least 80,430 yearly transports reported on the Neonatal/Pediatric Transport Team Database, with approximately 10% of those requiring medical oversight.

Specialty Pediatrics Frequency 2100 Percentage 50.00 %

Specialty Critical Care Frequency 2100 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Critical Care Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99472

SS Rec Summary

ISSUE: Pediatric Transport Supervision 99485

TAB: 13

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF	99339	Care plan oversight; 15-29 minutes per month		0.040			1.25			40	10					20			10																		
CURRENT				#DIV/0!						0																												
SVY	994885	Pediatric transport supervision; first 30 minutes	84	0.045	0.75	1.22	1.50	2.00	7.00	47	15			0	14	20	30	120	12																		
REC	99485	Pediatric transport supervision; first 30 minutes		0.045	1.50					47	15					20			12																		

AMA/Specialty Society RVS Update RUC Summary of Recommendations
CMS High Expenditure Procedure Codes screen

April 2012

Shaving of Epidermal or Dermal Lesions

At the January 2012 RUC meeting, the specialty society requested that shaving of epidermal or dermal lesions codes 11300-11313 be validated for physician time and work prior to surveying the Mohs surgery codes 17311 and 17312. CPT Mohs surgery codes 17311 and 17312 were identified through the CMS High Expenditure Procedural screen and are scheduled to be reviewed by the RUC at the April 2013 meeting. The RUC recommended review to validate physician time for codes 11300-11313 at the April 2012 meeting.

The RUC agreed with the specialty society that the previous CMS valuation of assigning these codes an RVU based on a percentage of another code was flawed. This flawed methodology provides compelling evidence to review the work RVUs.

11300 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
The RUC reviewed the survey results from 76 dermatologists for 11300 and determined that the 25th percentile work RVU of 0.60 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 9 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC used magnitude estimation and compared 11300 to reference code key reference service 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84) and MPC code 11721 Debridement *of nail(s) by any method(s); 6 or more* (work RVU = 0.54) and determined that the work required to perform this service is appropriate relative to these two services. **The RUC recommends a work RVU of 0.60 for CPT code 11300.**

11301 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
The RUC reviewed the survey results from 76 dermatologists for 11301 and determined that the 25th percentile work RVU of 0.90 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11301 to 11300 which requires 5 minutes less intra-service time to shave a smaller size lesion and determined the 0.90 maintains the proper rank order for this family of services. The RUC compared 11301 to reference code key reference service

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12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), which requires slightly less physician work and time, 10 versus 15 minutes respectively, to perform than 11301. **The RUC recommends a work RVU of 0.90 for CPT code 11301.**

11302 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
The RUC reviewed the survey results from 76 dermatologists for 11302 and determined that the median work RVU of 1.16 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11302 to 11301 which requires 5 minutes less intra-service time to shave a smaller size lesion and determined the 1.16 maintains the proper rank order for this family of services. The RUC also compared 11302 to 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14), which requires slightly less physician work and time, 15 versus 20 minutes respectively, to perform than 11302. **The RUC recommends a work RVU of 1.16 for CPT code 11302.**

11303 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
The RUC reviewed the survey results from 76 dermatologists for 11303 and determined that the 25th percentile work RVU of 1.25 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11303 to 11302 which requires 2 minutes less intra-service time to shave a smaller size lesion and determined the 1.25 maintains the proper rank order for this family of services. The RUC compared 11303 to key reference code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14 and 15 minutes intra service time) and MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)* (work RVU = 1.31 and 25 minutes intra-service time) to support the recommended value. **The RUC recommends a work RVU of 1.25 for CPT code 11303.**

11305 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

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The RUC noted that podiatry is the dominant provider of this service. APMA determined not to participate in the survey process, however, sent a letter of support for these work RVU recommendations.

The RUC reviewed the survey results from 66 dermatologists for 11305 and determined that the 25th percentile work RVU of 0.80 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11305 to 11300, and determined that 11305 requires 4 more minutes of intra-service time and is more intense and complex to perform than on the trunk, arms or legs. The RUC also compared 11305 to key reference code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14) and determined that 11305 requires less physician work and time to perform, 14 and 15 minutes intra-service time, respectively. The RUC determined a work RVU of 0.80 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 0.80 for CPT code 11305.**

11306 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
The RUC reviewed the survey results from 66 dermatologists for 11306 and determined that the survey median work RVU of 1.18 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11306 to 11301, and determined that 11306 requires 3 minutes more intra-service time and is more intense and complex to perform than on the trunk, arms or legs. The RUC compared 11306 to key reference code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14), which requires less physician work and time to perform, 18 and 15 minutes intra-service time, respectively. The RUC determined a work RVU of 1.18 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.18 for CPT code 11306.**

11307 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
The RUC reviewed the survey results from 66 dermatologists for 11307 and determined that the 25th percentile work RVU of 1.20 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11307 to 11302, and determined that 11307 requires 1 minute more intra-service time and is more

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intense and complex to perform than on the trunk, arms or legs. The RUC compared 11307 to key reference code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14), which requires less physician work and time to perform, 21 and 15 minutes intra-service time, respectively. The RUC determined a work RVU of 1.20 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.20 for CPT code 11307.**

11308 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
The RUC noted that podiatry is the dominant provider of this service. APMA determined not to participate in the survey process, however, sent a letter of support for these work RVU recommendations.

The RUC reviewed the survey results from 66 dermatologists for 11308 and determined that the 25th percentile work RVU of 1.46 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate any duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11308 to 11303, and determined that 11308 requires 4 more minutes intra-service time and is more intense and complex to perform than on the trunk, arms or legs. For additional support the RUC compared 11308 to similar services 12014 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm* (work RVU = 1.57 and 20 minutes intra-service time) and MPC code 29445 *Application of rigid total contact leg cast* (work RVU = 1.78 and 30 minutes intra-service time) and determined that 11308 was less intense and complex to perform. The RUC determined a work RVU of 1.46 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.46 for CPT code 11308.**

11310 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
The RUC reviewed the survey results from 68 dermatologists for 11310 and determined that the median work RVU of 1.19 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate any duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11310 to 11305 and determined that 11310 requires 6 minutes more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet, genitalia. The RUC determined a work RVU of 1.19 maintains the proper rank order for this family of services. The RUC compared 11310 to key reference code 11440 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less* (work RVU = 1.05) which requires less physician work and time to perform, 20 minutes and 10 minutes intra-service time, respectively. **The RUC recommends a work RVU of 1.19 for CPT code 11310.**

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11311 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
The RUC reviewed the survey results from 68 dermatologists for 11311 and determined that the median work RVU of 1.43 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11311 to 11306, and determined 11311 requires 7 more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet and genitalia. The RUC also compared 11311 to key reference code 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22) and determined 11311 requires more physician work and 10 more minutes of intra-service time to perform. The RUC determined a work RVU of 1.43 maintains the proper rank order for this family of services**. The RUC recommends a work RVU of 1.43 for CPT code 11311.**

11312 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
The RUC reviewed the survey results from 68 dermatologists for 11312 and determined that the median work RVU of 1.80 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 11 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11312 to 11307, and determined 11312 requires 9 more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet and genitalia. The RUC compared 11312 to MPC code 29445 *Application of rigid total contact leg cast* (work RVU=1.78) which requires similar physician work and 30 minutes of intra-service time to perform. The RUC determined a work RVU of 1.80 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.80 for CPT code 11312.**

11313 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
The RUC reviewed the survey results from 68 dermatologists for 11313 and determined that the median work RVU of 2.00 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 12 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11313 to 11308, and determined 11313 requires 9 more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet and genitalia. The RUC noted that the survey 25th percentile work RVU of 1.68 would not appropriately account for the physician work required to perform this service and would cause a rank order anomaly with the smaller shave code for this same body region, CPT code 11312. The RUC also compared 11313 to similar service 12015 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm* (work RVU = 1.98 and 25 minutes intra-service time). The RUC

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determined a work RVU of 2.00 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 2.00 for CPT code 11313.**

Shaving of epidermal or dermal lesion, single lesion

CPT Code	Pre-Eval	Pre-Posit	Pre-SDW	Intra	Imm Post	Survey Value	Rec wRVU
Trunk, arms or legs							
11300	0	1	5	10	5	25th	0.60
11301	0	1	5	15	5	25th	0.90
11302	0	1	5	20	5	Median	1.16
11303	0	1	5	22	5	25th	1.25
Scalp, neck, hands, feet, genitalia							
11305	0	1	5	14	5	25th	0.80
11306	0	1	5	18	5	Median	1.18
11307	0	1	5	21	5	25th	1.20
11308	0	1	5	26	5	25th	1.46
Face, ears, eyelids, nose, lips, mucous membrane							
11310	0	1	5	20	5	Median	1.19
11311	0	1	5	25	5	Median	1.43
11312	0	1	5	30	5	Median	1.80
11313	0	1	5	35	5	Median	2.00

Practice Expense

The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	000	0.60
11301	lesion diameter 0.6 to 1.0 cm	000	0.90
11302	lesion diameter 1.1 to 2.0 cm	000	1.16
11303	lesion diameter over 2.0 cm	000	1.25
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	000	0.80
11306	lesion diameter 0.6 to 1.0 cm	000	1.18
11307	lesion diameter 1.1 to 2.0 cm	000	1.20
11308	lesion diameter over 2.0 cm	000	1.46
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	000	1.19
11311	lesion diameter 0.6 to 1.0 cm	000	1.43
11312	lesion diameter 1.1 to 2.0 cm	000	1.80
11313	lesion diameter over 2.0 cm	000	2.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11300 Tracking Number Original Specialty Recommended RVU: 0.60
Presented Recommended RVU: 0.60
Global Period: 000 RUC Recommended RVU: 0.60

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion above the right breast with a diameter of 0.4cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD				
Specialty(s):	AAD				
CPT Code:	11300				
Sample Size:	240	**Resp N:**	76	**Response:** 31.6 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	15.00	**33.00**	80.00	900.00
Survey RVW:	0.50	0.60	**0.79**	0.80	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**2.00**		
Intra-Service Time:	1.00	5.00	**10.00**	13.00	15.00

Immediate Post Service-Time:	**9.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11300	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12001	000	0.84	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11721	000	0.54	**RUC Time**	7,631,434

CPT Descriptor 1 Debridement of nail(s) by any method(s); 6 or more

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 34.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 11300**	**Key Reference CPT Code:** 12001	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**21.00**	**22.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.82	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.75
Urgency of medical decision making	2.64	2.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.84	3.08
Physical effort required	2.56	2.89
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.61	2.84
Outcome depends on the skill and judgment of physician	3.00	3.21
Estimated risk of malpractice suit with poor outcome	2.68	2.81

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.38	2.64
Intra-Service intensity/complexity	2.55	3.02
Post-Service intensity/complexity	2.40	2.76

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 76 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on

the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 2 minutes positioning. Further, the CP recommends that 4 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12001 (Work RVU=0.84) and noted that although both the surveyed code and the reference code have the same intra-service time, 10 minutes, the reference code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the surveyed code.

In addition, the CP compared the surveyed code to MPC code 11721 (work RVU=0.54). The CP noted that the 11721 has 19 minutes of total service time and the surveyed code has 22 minutes of total service time.

		Pre	Intra	Post	Total	RVU
K-REF	12001	7	10	5	22	0.84
SVY	11300	7	10	5	22	0.60
MPC	11721	7	10	2	19	0.54

Based on these comparisons, the CP recommends 0.60 work RVUs, the 25th percentile for 11300.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11300

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Sometimes

Specialty Physicians Assistant How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 265326
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 3X Medicare Utilization

Specialty Dermatology Frequency 167023 Percentage 62.95 %

Specialty Family Practice Frequency 42240 Percentage 15.92 %

Specialty PAs, Internal Meds etc Frequency 56064 Percentage 21.13 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 88,442 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology Frequency 55675 Percentage 62.95 %

Specialty Family Practice Frequency 14080 Percentage 15.92 %

Specialty PAs, Internal Meds Frequency 18688 Percentage 21.13 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11300

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11301 Tracking Number

Original Specialty Recommended RVU: 0.90
Presented Recommended RVU: 0.90
RUC Recommended RVU: 0.90

Global Period: 000

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion above the right breast with a diameter of 0.8cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD				
Specialty(s):	AAD				
CPT Code:	11301				
Sample Size:	240	**Resp N:**	76	**Response:** 31.6 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	19.00	**40.00**	80.00	800.00
Survey RVW:	0.50	0.90	**0.98**	1.00	2.70
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	2.00	10.00	**15.00**	18.00	20.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11301	**Recommended Physician Work RVU: 0.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12001	000	0.84	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
56605	000	1.10	**RUC Time**	27,176

CPT Descriptor 1 Biopsy of vulva or perineum (separate procedure); 1 lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 32.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 11301**	**Key Reference CPT Code:** 12001	**Source of Time** **RUC Time**
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	15.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**26.00**	**22.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.97	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.84
Urgency of medical decision making	3.00	2.98
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.20	3.17
Physical effort required	3.03	2.90
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.04
Outcome depends on the skill and judgment of physician	3.27	3.21
Estimated risk of malpractice suit with poor outcome	2.94	2.97

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.80	2.70
Intra-Service intensity/complexity	3.10	3.10
Post-Service intensity/complexity	2.90	2.87

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 76 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 2 minutes positioning. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12001 (Work RVU=0.84) and noted that the surveyed code requires significantly more mental effort and judgment and greater risk for psychological stress in comparison to the reference code. Further, the CP noted that the total service time for the surveyed code exceeds the total service time for the reference code, 27 minutes and 22 minutes.

In addition, the CP compared the surveyed code to MPC code 56605 (work RVU=1.10). The CP noted that the 56605 has 35 minutes of total service time and the surveyed code has 27 minutes of total service time.

		Pre	Intra	Post	Total	RVU
MPC	56605	10	15	10	35	1.10
SVY	11301	7	15	5	27	0.90
K-Ref	12001	7	10	5	22	0.84

Based on these comparisons, the CP recommends 0.90 work RVUs, the 25th percentile for 11301.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11301

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Rarely

Specialty Physicians Assistant How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 528777
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 3X Medicare Utilizaton

Specialty Dermatology Frequency 386854 Percentage 73.16 %

Specialty Family Practice Frequency 49071 Percentage 9.28 %

Specialty PAs, Plastics etc Frequency 92854 Percentage 17.56 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 176,259
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology Frequency 128952 Percentage 73.16 %

Specialty Family Practice Frequency 16357 Percentage 9.28 %

Specialty PAs, Plastics etc Frequency 30952 Percentage 17.56 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11301

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11302 Tracking Number Original Specialty Recommended RVU: 1.05
Presented Recommended RVU: 1.05
Global Period: 000 RUC Recommended RVU: 1.16

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion above the right breast with a diameter 1.6cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD		
Specialty(s):	AAD		
CPT Code:	11302		
Sample Size:	240	**Resp N:** 76	**Response:** 31.6 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	15.00	**25.00**	53.00	700.00
Survey RVW:	0.57	1.05	**1.16**	1.25	3.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	2.00	14.00	**20.00**	24.00	26.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11302	**Recommended Physician Work RVU: 1.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11422	000	1.68	**RUC Time**

CPT Descriptor Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11100	000	0.81	**RUC Time**	2,702,007

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 23.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 11302**	**Key Reference CPT Code:** 11422	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**31.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.11	3.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	3.12
Urgency of medical decision making	3.05	3.19
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.30	3.48
Physical effort required	3.10	3.14
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.10	3.22
Outcome depends on the skill and judgment of physician	3.42	3.53
Estimated risk of malpractice suit with poor outcome	3.07	3.26

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.86	2.98
Intra-Service intensity/complexity	3.29	3.35
Post-Service intensity/complexity	3.00	3.11

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 76 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 11422 (Work RVU=1.68) and noted that the reference code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the surveyed code. Further, the CP noted that the total service time for the reference code exceeds the total service time for the surveyed code, 56 minutes and 36 minutes.

In addition, the CP compared the surveyed code to MPC code 11100 (work RVU=0.81). The CP noted that the 11100 has 22 minutes of total service time and the surveyed code has 33 minutes of total service time.

		Pre	Intra	Post	Total	RVU
K-Ref	11422	10	25	5	56	1.68
SVY	11302	6	20	5	31	1.16
MPC	11100	5	12	5	22	0.81

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11302

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Rarely

Specialty Physicians Assistant How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 321522
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 250788 Percentage 78.00 %

Specialty Family Practice Frequency 24179 Percentage 7.52 %

Specialty PAs, Plastics etc Frequency 46557 Percentage 14.48 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 107,174
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology Frequency 83596 Percentage 78.00 %

Specialty Family Practice Frequency 8060 Percentage 7.52 %

Specialty PAs, Plastics et Frequency 15519 Percentage 14.48 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11302

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11303 Tracking Number Original Specialty Recommended RVU: **1.25**
Presented Recommended RVU: **1.25**
Global Period: 000 RUC Recommended RVU: **1.25**

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion above the right breast with a diameter 2.3cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD		
Specialty(s):	AAD		
CPT Code:	11303		
Sample Size:	240	**Resp N:** 76	**Response:** 31.6 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**15.00**	46.50	600.00
Survey RVW:	0.70	1.25	**1.46**	1.60	2.80
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	2.00	15.00	**22.00**	28.00	32.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11303	**Recommended Physician Work RVU: 1.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**22.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12002	000	1.14	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11755	000	1.31	**RUC Time**	28,294

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 21.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 11303**	**Key Reference CPT Code:** 12002	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	22.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**33.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	2.94
Urgency of medical decision making	3.51	3.17
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.82	3.40
Physical effort required	3.55	3.21
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.64	3.21
Outcome depends on the skill and judgment of physician	3.88	3.44
Estimated risk of malpractice suit with poor outcome	3.56	3.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.34	2.98
Intra-Service intensity/complexity	3.82	3.35
Post-Service intensity/complexity	3.52	3.10

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 76 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 6 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12002 (Work RVU=1.14) and noted that the surveyed code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. Further, the CP noted that the total service time for the surveyed code exceeds the total service time for the reference code, 36 minutes and 27 minutes.

In addition, the CP compared the surveyed code to MPC code 11755 (work RVU=1.31). The CP noted that the 11755 has 55 minutes of total service time and the surveyed code has 36 minutes of total service time.

		Pre	Intra	Post	Total	RVU
MPC	11755	15	25	15	55	1.31
SVY	11303	6	22	5	33	1.25
K-Ref	12002	7	15	5	27	1.14

Based on these comparisons, the CP recommends 1.25 work RVUs, the 25th percentile for 11303.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11303

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Sometimes

Specialty Plastic & Reconstructive Surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 50835
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 3X Medicare Utilization

Specialty Dermatology Frequency 36500 Percentage 71.80 %

Specialty Family Practice Frequency 5338 Percentage 10.50 %

Specialty Plastics, IM etc Frequency 8998 Percentage 17.70 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 16,945 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 12167 Percentage 71.80 %

Specialty Family Practice Frequency 1780 Percentage 10.50 %

Specialty Plastics, IM etc Frequency 3000 Percentage 17.70 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11303

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11305 Tracking Number Original Specialty Recommended RVU: 0.80
Presented Recommended RVU: 0.80
Global Period: 000 RUC Recommended RVU: 0.80

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her scalp with a diameter of 0.4 cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 50%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal..

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD				
Specialty(s):	American Academy of Dermatology				
CPT Code:	11305				
Sample Size:	240	**Resp N:**	66	**Response:** 27.5 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	15.00	**28.00**	98.00	1000.00
Survey RVW:	0.52	0.80	**0.92**	1.00	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	1.00	11.00	**14.00**	15.00	18.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11305	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**14.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12002	000	1.14	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
65205	000	0.71	**RUC Time**	34,470

CPT Descriptor 1 Removal of foreign body, external eye; conjunctival superficial

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
69100	000	0.81	**RUC Time**

CPT Descriptor Biopsy External Ear

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 36.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 11305**	**Key Reference CPT Code:** 12002	**Source of Time RUC Time**
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	14.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**25.00**	**27.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.01	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.74	3.03
Urgency of medical decision making	2.74	3.09
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.92	3.21
Physical effort required	2.60	3.04
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.74	3.00
Outcome depends on the skill and judgment of physician	3.06	3.21
Estimated risk of malpractice suit with poor outcome	2.74	2.96

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.58	2.81
Intra-Service intensity/complexity	2.69	3.00
Post-Service intensity/complexity	2.42	2.77

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 66 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12002 (Work RVU=1.14) and noted that the reference code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the surveyed code.

In addition, the CP compared the surveyed code to reference code 69100 (work RVU=0.81). The CP noted that the 69100 has 7 minutes of pre-service time, 12 minutes of intra-service time and 5 minutes of post-service time which is very similar to the recommended time for 11305, 8 minutes of pre-service time, 14 minutes of intra-service time and 5 minutes of post time. Further comparison codes include MPC code 65205 (Work RVU=0.71). The CP noted that 65205 has 15 minutes of total service time as compared to the surveyed code which as 27 minutes of total service time.

	CPT Code	Pre	Intra	Post	Total	RVU
Key Ref	12002	7	15	5	27	1.14
Ref	69100	7	12	5	24	0.81
SVY	11305	6	14	5	25	0.80
MPC	65205	5	5	5	15	0.71

Based on these comparisons, the CP recommends 0.80 work RVUs, the 25th percentile for 11305.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11305

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Sometimes

Specialty Podiatry How often? Commonly

Specialty Family Practice How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 346419
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate 3X Medicare utilization

Specialty Dermatology Frequency 67760 Percentage 19.56 %

Specialty Podiatry Frequency 241455 Percentage 69.70 %

Specialty Family Practice, PAs etc Frequency 37206 Percentage 10.74 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 115,473
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 22587 Percentage 19.56 %

Specialty Podiatry Frequency 80485 Percentage 69.70 %

Specialty Family Practice, PAs etc Frequency 12402 Percentage 10.74 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11305

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11306 Tracking Number Original Specialty Recommended RVU: 1.18
Presented Recommended RVU: 1.18
Global Period: 000 RUC Recommended RVU: 1.18

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her scalp with a diameter 0.8cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD				
Specialty(s):	American Academy of Dermatology				
CPT Code:	11306				
Sample Size:	240	**Resp N:**	66	**Response:** 27.5 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	15.00	**27.00**	98.00	1000.00
Survey RVW:	0.55	0.96	**1.18**	1.25	1.80
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	1.00	14.00	**18.00**	21.00	25.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11306	**Recommended Physician Work RVU: 1.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**18.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12002	000	1.14	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11100	000	0.81	**RUC Time**	2,702,007

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 34.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 11306**	**Key Reference CPT Code:** 12002	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	18.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**29.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.98	3.04
Urgency of medical decision making	2.98	3.12
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.26	3.29
Physical effort required	2.89	3.08
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.03
Outcome depends on the skill and judgment of physician	3.34	3.25
Estimated risk of malpractice suit with poor outcome	3.01	3.04

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.86	2.91
Intra-Service intensity/complexity	3.10	3.17
Post-Service intensity/complexity	2.80	2.92

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 66 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. The CP reviewed the survey time for intra-service and agrees that this time was overestimated and therefore recommends the 25th percentile for intra-service time, 14 minutes. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12002 (Work RVU=1.14) and noted that the reference code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. Further, the CP noted that the intra-service time for the reference code exceeds the intra-service time for the surveyed code, 15 minutes and 14 minutes.

In addition, the CP compared the surveyed code to MPC code 11100 (work RVU=0.81). The CP noted that the 11100 has 22 minutes of total service time and the surveyed code has 25 minutes of total service time.

		Pre	Intra	Post	Total	RVU
K-Ref	12002	7	15	5	27	1.14
SVY	11306	6	14	5	25	1.18
MPC	11100	5	12	5	22	0.81

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11306

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Podiatry How often? Sometimes

Specialty Family Practice How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 313050
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated 3x Medicare Utilization

Specialty Dermatology Frequency 143252 Percentage 45.76 %

Specialty Podiatry Frequency 121151 Percentage 38.70 %

Specialty Family Practice, PAs etc Frequency 48648 Percentage 15.54 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 104,350
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 47751 Percentage 45.76 %

Specialty Podiatry Frequency 40384 Percentage 38.70 %

Specialty Family Practice, PAs etc Frequency 16216 Percentage 15.54 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11306

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11307 Tracking Number Original Specialty Recommended RVU: 1.20
Presented Recommended RVU: 1.20
Global Period: 000 RUC Recommended RVU: 1.20

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her scalp with a diameter of 1.6 cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 47%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD				
Specialty(s):	American Academy of Dermatology				
CPT Code:	11307				
Sample Size:	240	**Resp N:**	66	**Response:** 27.5 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	12.50	**20.00**	40.00	1000.00
Survey RVW:	0.51	1.20	**1.45**	1.57	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	1.00	15.00	**21.00**	25.00	30.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11307	**Recommended Physician Work RVU: 1.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**21.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12002	000	1.14	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11755	000	1.31	**RUC Time**	28,294

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 31.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 11307**	**Key Reference CPT Code:** 12002	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	21.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**32.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.69	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.06
Urgency of medical decision making	3.42	3.18
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.77	3.42
Physical effort required	3.43	3.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.47	3.12
Outcome depends on the skill and judgment of physician	3.81	3.40
Estimated risk of malpractice suit with poor outcome	3.46	3.16

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.29	3.02
Intra-Service intensity/complexity	3.63	3.30
Post-Service intensity/complexity	3.33	3.02

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 66 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12002 (Work RVU=1.14) and noted that the surveyed code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. Further, the CP noted that the total service time for the surveyed code exceeds the total service time for the reference code, 34 minutes and 27 minutes.

In addition, the CP compared the surveyed code to MPC code 11755 (work RVU=1.31). The CP noted that the 11755 has 55 minutes of total service time and the surveyed code has 34 minutes of total service time.

		Pre	Intra	Post	Total	RVU
MPC	11755	15	25	15	55	1.31
SVY	11307	6	21	5	32	1.20
K-Ref	12002	7	15	5	27	1.14

Based on these comparisons, the CP recommends 1.20 work RVUs, the 25th percentile for 11307.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11307

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Podiatry How often? Sometimes

Specialty Family Practice How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 149865
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate 3X Medicare Utilization

Specialty Dermatology Frequency 83760 Percentage 55.89 %

Specialty Podiatry Frequency 44855 Percentage 29.93 %

Specialty Family Practice, Plastics etc Frequency 21251 Percentage 14.18 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 49,955 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 27920 Percentage 55.89 %

Specialty Podiatry Frequency 14952 Percentage 29.93 %

Specialty Family Practice, Plastics etc Frequency 7084 Percentage 14.18 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11307

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11308 Tracking Number Original Specialty Recommended RVU: **1.46**
Presented Recommended RVU: **1.46**
Global Period: 000 RUC Recommended RVU: **1.46**

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her scalp with a diameter of 2.3cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD		
Specialty(s):	American Academy of Dermatology		
CPT Code:	11308		
Sample Size:	240	**Resp N:** 66	**Response:** 27.5 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**20.00**	40.00	1000.00
Survey RVW:	0.75	1.46	**1.83**	1.91	3.30
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	1.00	17.00	**26.00**	30.00	36.00

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11308	**Recommended Physician Work RVU: 1.46**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**26.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12002	000	1.14	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29445	000	1.78	**RUC Time**	16,943

CPT Descriptor 1 Application of rigid total contact leg cast

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 22.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 11308**	**Key Reference CPT Code: 12002**	**Source of Time RUC Time**
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	26.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**37.00**	**27.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	3.13
Urgency of medical decision making	3.69	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.06	3.55
Physical effort required	3.80	3.32
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.82	3.23
Outcome depends on the skill and judgment of physician	4.09	3.47
Estimated risk of malpractice suit with poor outcome	3.72	3.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.52	3.17
Intra-Service intensity/complexity	3.91	3.50
Post-Service intensity/complexity	3.50	3.27

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 66 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 7 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12002 (Work RVU=1.14) and noted that the surveyed code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. Further, the CP noted that the total service time for the surveyed code exceeds the total service time for the reference code, 39 minutes and 27 minutes.

In addition, the CP compared the surveyed code to MPC code 29445 (work RVU=1.78). The CP noted that the 29445 has 50 minutes of total service time and the surveyed code has 37 minutes of total service time.

		Pre	Intra	Post	Total	RVU
MPC	29445	15	30	5	50	1.78
SVY	11308	6	26	5	37	1.46
K-Ref	12002	7	15	5	27	1.14

Based on these comparisons, the CP recommends 1.46 work RVUs, the 25th percentile for 11308.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11308

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Podiatry How often? Commonly

Specialty Dermatology How often? Sometimes

Specialty Family Practice How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 34167
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate 3X MedicareUtilization

Specialty pODIATRY Frequency 18594 Percentage 54.42 %

Specialty Dermatology Frequency 10934 Percentage 32.00 %

Specialty Family Practice, Plastics etc Frequency 4640 Percentage 13.58 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,389 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Podiatry Frequency 6198 Percentage 54.42 %

Specialty Dermatology Frequency 3645 Percentage 32.00 %

Specialty Family Practice, Plastics etc Frequency 1547 Percentage 13.58 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11308

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11310 Tracking Number Original Specialty Recommended RVU: 0.80
Presented Recommended RVU: 0.80
Global Period: 000 RUC Recommended RVU: 1.19

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her cheek with a diameter of 0.4cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD		
Specialty(s):	American Academy of Dermatology		
CPT Code:	11310		
Sample Size:	240	**Resp N:** 68	**Response:** 28.3 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	14.75	**23.50**	58.50	1425.00
Survey RVW:	0.50	0.80	**1.19**	1.25	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	1.00	5.00	**20.00**	23.00	26.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11310	**Recommended Physician Work RVU: 1.19**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11440	010	1.05	**RUC Time**

CPT Descriptor Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	152,826

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 23.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 11310**	**Key Reference CPT Code:** 11440	**Source of Time RUC Time**
Median Pre-Service Time	6.00	5.00	
Median Intra-Service Time	20.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**31.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.02
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.76
Urgency of medical decision making	2.78	2.94
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.06	3.22
Physical effort required	2.63	2.91
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.79	2.97
Outcome depends on the skill and judgment of physician	3.13	3.22
Estimated risk of malpractice suit with poor outcome	2.80	2.97

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.49	2.78
Intra-Service intensity/complexity	2.79	3.13
Post-Service intensity/complexity	2.45	2.81

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 68 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

Although, the CP noted that the total service time for the surveyed code has less total service time as compared to the reference code is 33 minutes and 36 minutes, respectively. Further, the CP reviewed the surveyed code in comparison to the key reference code 11440 (Work RVU=1.05) and noted that the reference code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code.

In addition, the CP compared the surveyed code to MPC code 20551 (work RVU=0.75). The CP noted that the 20551 has 20 minutes of total service time and the surveyed code has 31 minutes of total service time.

		Pre	Intra	Post	Total	RVU
K-RSL	11440	5	10	5	36	1.05
SVY	11310	6	20	5	31	1.18
MPC	20551	10	5	5	20	0.75

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11310

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Sometimes

Specialty Plastics & Reconstructive Surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 257814
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate 3X Medicare Utilization

Specialty Dermatology Frequency 161134 Percentage 62.50 %

Specialty Family Practice Frequency 29778 Percentage 11.55 %

Specialty Plastics, NPs etc Frequency 66903 Percentage 25.95 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 85,938 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 53712 Percentage 62.50 %

Specialty Family Practice Frequency 9926 Percentage 11.55 %

Specialty Plastics, NPs etc Frequency 22301 Percentage 25.95 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11310

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11311 Tracking Number Original Specialty Recommended RVU: **1.43**
Presented Recommended RVU: **1.43**
Global Period: 000 RUC Recommended RVU: **1.43**

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her cheek with a diameter 0.8cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Mark Kaufmann, MD; Brett Coldiron, MD				
Specialty(s):	American Academy of Dermatology				
CPT Code:	11311				
Sample Size:	240	**Resp N:**	68	**Response:** 28.3 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	15.00	**25.00**	53.00	400.00
Survey RVW:	0.65	1.10	**1.43**	1.50	3.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	4.00	16.00	**25.00**	27.00	32.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11311	**Recommended Physician Work RVU: 1.43**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12013	000	1.22	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
12011	000	1.07	**RUC Time**	88,270

CPT Descriptor 2 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
11730	000	1.10	**RUC Time**

CPT Descriptor Avulsion of nail plate, partial or complete, simple; single

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 41.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 11311**	**Key Reference CPT Code:** 12013	**Source of Time RUC Time**
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	25.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**36.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.92	2.79
Urgency of medical decision making	3.11	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.42	3.30
Physical effort required	2.98	2.97
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.19	2.97
Outcome depends on the skill and judgment of physician	3.45	3.23
Estimated risk of malpractice suit with poor outcome	3.22	3.04

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.90	2.81
Intra-Service intensity/complexity	3.20	3.25
Post-Service intensity/complexity	2.90	2.94

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 68 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. The CP reviewed the survey time for intra-service and agrees that this time was overestimated and therefore recommends the 25th percentile for intra-service time, 16 minutes. Further, the CP recommends that 5 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12013 (Work RVU=1.22) and noted that the reference code and the surveyed code require similar mental effort and judgment, technical skill, physical effort and overall similarly intense services to perform. Further, the CP noted that the intra-service time for the reference code is similar to the intra-service time for the surveyed code, 15 minutes and 16 minutes. Despite the similarity in time and intensity, the CP recommends a value slightly less than the current value of the key reference code.

In addition, the CP compared the surveyed code to MPC code 12011 (work RVU=1.07). The CP noted that the 12011 has 24 minutes of total service time and the surveyed code has 29 minutes of total service time. Further, the CP compared the surveyed code to reference code 11730 (Work RVU=1.10). The CP noted that despite the same value, the MPC code had a longer total time as compared to the surveyed code, 37 minutes and 27 minutes.

		Pre	Intra	Post	Total	RVU
K-Ref	12013	7	15	5	27	1.22
Ref	11730	15	12	10	37	1.10
SVY	11311	6	16	5	27	1.43
MPC	12011	7	12	5	24	1.07

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11311

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Rarely

Specialty Plastic & Reconstructive Surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 359280
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate 3X Medicare Utilization

Specialty Dermatology Frequency 260155 Percentage 72.41 %

Specialty Family Practice Frequency 23821 Percentage 6.63 %

Specialty Plastics, PAs etc Frequency 75306 Percentage 20.96 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 119,760
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Meciare Claims Data

Specialty Dermatology Frequency 86719 Percentage 72.41 %

Specialty Family Practice Frequency 7941 Percentage 6.63 %

Specialty Plastics, PAs etc Frequency 25102 Percentage 20.96 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11311

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11312 Tracking Number

Original Specialty Recommended RVU: 1.30
Presented Recommended RVU: 1.30
RUC Recommended RVU: 1.80

Global Period: 000

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her cheek with a diameter 1.6cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Mark Kaufman, MD; Brett Coldiron, MD		
Specialty(s):	American Academy of Dermatology		
CPT Code:	11312		
Sample Size:	240	**Resp N:** 68	**Response:** 28.3 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**23.00**	50.00	400.00
Survey RVW:	0.95	1.30	**1.80**	1.90	5.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	3.00	12.00	**30.00**	32.00	37.00

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11312	**Recommended Physician Work RVU: 1.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12013	000	1.22	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11755	000	1.31	**RUC Time**	28,294

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 39.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 11312**	**Key Reference CPT Code:** 12013	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	30.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**41.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.61	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.32	2.88
Urgency of medical decision making	3.41	3.07
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.82	3.36
Physical effort required	3.42	3.04
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.54	3.10
Outcome depends on the skill and judgment of physician	3.77	3.30
Estimated risk of malpractice suit with poor outcome	3.52	3.19

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.23	2.79
Intra-Service intensity/complexity	3.69	3.27
Post-Service intensity/complexity	3.36	2.94

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 68 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 6 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12013 (Work RVU=1.22) and noted that the surveyed code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. Further, the CP noted that the total service time for the surveyed code exceeds the total service time for the reference code, 43 minutes and 27 minutes.

In addition, the CP compared the surveyed code to MPC code 11755 (work RVU=1.31). The CP noted that the 11755 has 55 minutes of total service time and the surveyed code has 41 minutes of total service time.

		Pre	Intra	Post	Total	RVU
MPC	11755	15	25	15	55	1.31
SVY	11312	6	30	5	41	1.80
K-Ref	12013	7	15	5	27	1.22

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11312

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastics & Reconstructive Surgery How often? Rarely

Specialty Family Practice How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 157848
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate 3X Medicare Utilization

Specialty Dermatology Frequency 121543 Percentage 77.00 %

Specialty Plastics & Reconstructive Surgery Frequency 10497 Percentage 6.65 %

Specialty Family Practice PAs etc Frequency 25809 Percentage 16.35 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 52,616 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 40515 Percentage 77.00 %

Specialty Plastics Frequency 3499 Percentage 6.65 %

Specialty Family Practice, PAs etc Frequency 8603 Percentage 16.35 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11312

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11313 Tracking Number Original Specialty Recommended RVU: 1.68
Presented Recommended RVU: 1.68
Global Period: 000 RUC Recommended RVU: 2.00

CPT Descriptor: Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female presents for the removal of an atypical pigmented lesion on her cheek with a diameter of 2.3cm. The lesion warrants complete removal for thorough pathologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Positioning: Based upon lesion location and the technical detail required of the procedure, the patient is positioned for maximum flexibility for the surgeon while maintaining patient comfort. Records are checked to confirm patient, procedure and site. A photograph of the lesion is taken, printed and scanned/inserted into the patient's chart. The area is prepped, anaesthetized and draped. Anesthesia is injected in both subcutaneous and dermal compartments so that it results in a "raising" of the lesion to facilitate appropriate dermal depth removal.

Description of Intra-Service Work: Based on lesion type, size, and skin location, relaxed skin tension lines are marked. The dermal thickness in the location is evaluated, and then a margin between 2 to 5 mm is delineated with a surgical marker. The outline of the mark is scored using a scalpel. Starting at one end of the lesion the dermis is incised at anywhere from a 30 to 60 degree angle, to coincide with the leading edge of the skin lesion and to ensure that the path of removal is fully under the lesion yet still in the dermis. Hemostasis is achieved as needed, usually with pressure or topical application of aluminum chloride. The angle of dissection is then straightened to run parallel to the axis of the lesion, while remaining in the dermis. The shave proceeds forward following the pre-determined marked outline. As the dissection proceeds, the lesion is retracted as needed. This is accomplished by the placement of an initial suture to mark a border or retraction hooks or non-crushing forceps. The suture location is documented. As the midpoint is reached the dermal depth is checked to ensure that the fat is not penetrated and that the lesion appears in the entirety of the removed sample. Following the outline and maintaining a 30 to 60% transverse exit angle the lesion is removed. Additional hemostasis is achieved as above. Should further hemostasis need to be achieved, a fast-absorbing suture ligature or electrocautery can be utilized.

Description of Post-Service Work: The treatment site is monitored for delayed bleeding. An appropriate dressing for location and size is chosen (larger lesions might require Duoderm or some other flexible temporary skin substitute) and applied. Side effects, including pain, infection, oozing, and scaring are once again discussed with the patient, and the patient is discharged

with appropriate analgesics and wound care instructions. The specimen is sent to pathology with a request for thorough examination.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Mark Kaufman, MD; Brett Coldiorn, MD		
Specialty(s):	American Academy of Dermatology		
CPT Code:	11313		
Sample Size:	240	**Resp N:** 68	**Response:** 28.3 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**15.00**	26.00	400.00
Survey RVW:	0.83	1.68	**2.00**	2.20	6.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	2.00	11.00	**35.00**	38.00	48.00

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	11313	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12013	000	1.22	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64449	000	1.81	**RUC Time**	5,416

CPT Descriptor 1 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 35.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 11313**	**Key Reference CPT Code:** 12013	**Source of Time** RUC Time
Median Pre-Service Time	6.00	7.00	
Median Intra-Service Time	35.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**46.00**	**27.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	2.91
Urgency of medical decision making	3.86	3.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.26	3.48
Physical effort required	3.85	3.08
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.05	3.20
Outcome depends on the skill and judgment of physician	4.17	3.42
Estimated risk of malpractice suit with poor outcome	3.98	3.26

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.74	2.94
Intra-Service intensity/complexity	4.28	3.41
Post-Service intensity/complexity	3.87	3.07

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) has conducted a random survey of this code. Using the member database we identified both surgical and non-surgical members on the assumption that both surgical and general dermatologists would have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of members.

The AAD Consensus Panel (CP) reviewed the survey data from 68 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made based on the fact that this service is typically performed with an E&M service. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 5 minutes evaluation, 3 minutes positioning. Further, the CP recommends that 7 minutes be removed from the post service time period, to make consistent with other similar surgical procedures.

The CP reviewed the surveyed code in comparison to the key reference code 12013 (Work RVU=1.22) and noted that the surveyed code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. Further, the CP noted that the total service time for the surveyed code exceeds the total service time for the reference code, 46 minutes and 27 minutes.

In addition, the CP compared the surveyed code to MPC code 64449 (work RVU=1.81). The CP noted that the 64449 has 60 minutes of total service time and the surveyed code has 46 minutes of total service time.

		Pre	Intra	Post	Total	RVU
MPC	64449	29	20	11	60	1.81
SVY	11313	6	35	5	46	2.00
K-Ref	12013	7	15	5	27	1.22

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the CP that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11313

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic & REconstructive Surgery How often? Rarely

Specialty Family Practice How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 21678
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 15171 Percentage 69.98 %

Specialty Plastics Frequency 1821 Percentage 8.40 %

Specialty Family Practice, Gen Surg etc Frequency 4687 Percentage 21.62 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,226 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 5057 Percentage 69.98 %

Specialty Plastics Frequency 607 Percentage 8.40 %

Specialty Family Practice, Gen Surg etc Frequency 1562 Percentage 21.61 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11313

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

Compelling Evidence: Shave Codes

The American Academy of Dermatology (AAD) would like to submit the following compelling evidence for the shave codes. The AAD contends that:

Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, ***such as****: a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation*

- The whole family of shave codes was previously reviewed by the RUC, but never surveyed and the results appeared in HCFA's December 2, 1993 final rule. At the time HCFA decided that the shave excision codes should be valued at 60% of the other excision codes, the 11400 series.

- The original RUC recommendation to HCFA was that "the shave codes should be valued at 80% of the other excision codes. The current values are already below what the RUC recommended. Therefore, the current values should be maintained." Both of these percentages were arbitrarily selected.

The AAD contends that this mechanism for valuation is **not** valid as it is not based on survey data or careful comparative relativity to any codes within the Fee Schedule. Therefore, relativity to other codes was not established by any recognized RUC standard.

- Since that time the excision codes have been redefined to INCLUDE the margins, using the phrase "excised diameter". There was no corresponding change in the shave codes values to reflect the shift in the definition: shave remained the lesion size, while the excision codes, which they were valued upon, shifted upwards. This shift passed budget neutrality according to the Medicare numbers in the RUC dbase, and was approved by the RUC.

- In addition, since there was never a breakout of times into pre, intra and post the RUC asked the Specialty society to do that, and a consensus panel suggested times. Please note that these time breakout were not derived from any survey. These times were approved by the RUC.

Based on this valuation history, the AAD contends that there is compelling evidence that incorrect assumptions were made in the previous valuation of these services. The specialty respectfully recommends that the RUC accept the survey value work RVUs (at the 25th percentile).

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12001	Simple repair of superficial		0.059			0.84			22	5	1	1			10			5																
CURRENT	11300	Shaving of epidermal or		0.036			0.51			18	5					8			5																
SVY	11300	Shaving of epic	76	0.042	0.50	0.60	0.79	0.80	2.00	28	5	2	2	2	5	10	13	15	9																
RUC REC	11300	Shaving of epidermal		0.043			0.60			21	0	1	5			10			5																

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TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12001	Simple repair of superficial		0.059			0.84			22	5	1	1			10			5																
CURRENT	11301	Shaving of epidermal or		0.042			0.85			25	5					15			5																
SVY	11301	Shaving of epic	76	0.039	0.50	0.90	0.98	1.00	2.70	35	5	2	3	2	10	15	18	20	10																
RUC REC	11301	Shaving of epidermal		0.048			0.90			26	0	1	5			15			5																

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TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	11422	Excision, benign lesion		0.035			1.68			56	10					25			5															1	
CURRENT	11302	Shaving of epidermal or		0.046			1.05			29	7					17			5																
SVY	11302	Shaving of epic	76	0.038	0.57	1.05	1.16	1.25	3.50	41	5	3	3	2	14	20	24	26	10																
RUC REC	11302	Shaving of epidermal		0.049			1.16			31	0	1	5			20			5																

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TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs			Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12002	Simple repair of superficial		0.059			1.14			27	5	1	1			15			5															
CURRENT	11303	Shaving of epidermal or		0.045			1.24			35	10					20			5															
SVY	11303	Shaving of epic	76	0.046	0.70	1.25	1.46	1.60	2.80	44	6	3	3	2	15	22	28	32	10															
RUC REC	11303	Shaving of epidermal		0.049			1.25			33	0	1	5			22			5															

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TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs			Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12002	Simple repair of superficial		0.059			1.14			27	5	1	1			15			5															
CURRENT	11305	Shaving of epidermal or		0.037			0.67			22	5					12			5															
SVY	11305	Shaving of epic	66	0.035	0.52	0.80	0.92	1.00	2.00	35	5	3	3	1	11	14	15	18	10															
RUC REC	11305	Shaving of epidermal		0.045			0.80			25	0	1	5			14			5															

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Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs			Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12002	Simple repair of superficial		0.059			1.14			27	5	1	1			15			5															
CURRENT	11306	Shaving of epidermal or		0.048			0.99			26	5					16			5															
SVY	11306	Shaving of epic	66	0.042	0.55	0.96	1.18	1.25	1.80	39	5	3	3	1	14	18	21	25	10															
RUC REC	11306	Shaving of epidermal		0.056			1.18			29	0	1	5			18			5															

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Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs			Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12002	Simple repair of superficial		0.059			1.14			27	5	1	1			15			5															
CURRENT	11307	Shaving of epidermal or		0.048			1.14			30	7					18			5															
SVY	11307	Shaving of epic	66	0.048	0.51	1.20	1.45	1.57	3.00	43	5	3	4	1	15	21	25	30	10															
RUC REC	11307	Shaving of epidermal		0.049			1.20			32	0	1	5			21			5															

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TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs			Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12002	Simple repair of superficial		0.059			1.14			27	5	1	1			15			5															
CURRENT	11308	Shaving of epidermal or		0.049			1.41			37	10					22			5															
SVY	11308	Shaving of epic	66	0.053	0.75	1.46	1.83	1.91	3.30	50	5	3	4	1	17	26	30	36	12															
RUC REC	11308	Shaving of epidermal		0.049			1.46			37	0	1	5			26			5															

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs			Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	11440	Excision, other benign		0.035			1.05			36	5					10			5															1
CURRENT	11310	Shaving of epidermal or		0.039			0.73			23	5					13			5															
SVY	11310	Shaving of epic	68	0.038	0.50	0.80	1.19	1.25	3.00	41	5	3	3	1	5	20	23	26	10															
RUC REC	11310	Shaving of epidermal		0.051			1.19			31	0	1	5			20			5															

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12013	Simple repair of superficial		0.035			1.22			27	5	1	1			15			5																
CURRENT	11311	Shaving of epidermal or		0.046			1.05			28	5					18			5																
SVY	11311	Shaving of epid	68	0.040	0.65	1.10	1.43	1.50	3.50	47	5	3	4	4	16	25	27	32	10																
RUC REC	11311	Shaving of epidermal		0.050			1.43			36	0	1	5			25			5																

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12013	Simple repair of superficial		0.035			1.22			27	5	1	1			15			5																
CURRENT	11312	Shaving of epidermal or		0.047			1.20			32	7					20			5																
SVY	11312	Shaving of epid	68	0.045	0.95	1.30	1.80	1.90	5.00	53	5	3	4	3	12	30	32	37	11																
RUC REC	11312	Shaving of epidermal		0.054			1.80			41	0	1	5			30			5																

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 38

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12013	Simple repair of superficial		0.035			1.22			27	5	1	1			15			5																
CURRENT	11313	Shaving of epidermal or		0.054			1.62			39	10					24			5																
SVY	11313	Shaving of epid	68	0.043	0.83	1.68	2.00	2.20	6.00	59	5	3	4	2	11	35	38	48	12																
RUC REC	11313	Shaving of epidermal		0.052			2.00			46	0	1	5			35			5																

CPT Code: 11300; 11301; 11302; 11303; 11305; 11306; 11307; 11308; 11310; 11311; 11312; 11313

Specialty Society('s): American Academy of Dermatology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

11300 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less

11301 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm

11302 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm

11303 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm

11305 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

11306 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm

11307 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm

11308 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm

11310 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

11311 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm

11312 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm

11313 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm

Global Period: **000** Meeting Date: **April 2012**

CPT Code: 11300; 11301; 11302; 11303; 11305; 11306; 11307; 11308; 11310; 11311; 11312; 11313

Specialty Society('s): American Academy of Dermatology

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AAD RB/RVS committee has reviewed the RUC approved PE direct inputs for these codes as well as determined from industry data that there are no significant additions or changes to these inputs. The AAD Coding & Reimbursement Task Force as well as the RUC advisors for AAD, ASDS, ACMS and SID serve on the AAD RB/RVS committee.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Please see PE Direct input spreadsheet.

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11300		CPT Code # 11300		CPT Code # 11301		CPT Code # 11301		CPT Code # 11302		CPT Code # 11302		CPT Code # 11303		CPT Code # 11303	
3	Meeting Date: April 2012	CMS Code	Staff Type	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			0		0		0		0				0				0	
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	21.0	0.0	24.0	0.0			27.0	0.0			30.0	0.0			32.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	21.0	0.0	24.0	0.0	27.0	0.0	27.0	0.0	32.0	0.0	30.0	0.0	47.0	0.0	32.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE																		
11	Start: Following visit when decision for surgery or procedure made																		
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA																
13	Coordinate pre-surgery services		RN/LPN/MTA																
14	Schedule space and equipment in facility		RN/LPN/MTA																
15	Provide pre-service education/obtain consent		RN/LPN/MTA																
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - *specify:*																		
18	End: When patient enters office/facility for surgery/procedure																		
19	SERVICE PERIOD																		
20	Start: When patient enters office/facility for surgery/procedure:																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		RN/LPN/MTA	3				3				3				3			
22	Obtain vital signs		RN/LPN/MTA	3				3				3				3			
23	Provide pre-service education/obtain consent		RN/LPN/MTA	2				2				2				2			
24	Prepare room, equipment, supplies		RN/LPN/MTA	2		2		2		2		2		2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV		RN/LPN/MTA	3		3		3		3		3		3		3		3	
26	Intra-service																		
27	Assist physician in performing procedure		RN/LPN/MTA	7		7		9		10		12		13		25		15	
28	Post-Service																		
29	Clean room/equipment by physician staff		RN/LPN/MTA	1				1				1				2			
30	Complete diagnostic forms, lab & X-ray requisitions		RN/LPN/MTA			2		2		2		2		2		2		2	
31	Clean Surgical Instrument Package		RN/LPN/MTA			10				10				10				10	
32	Complete diagnostic forms, lab & X-ray requisitions		RN/LPN/MTA					2				2				2			
33	Review/read X-ray, lab, and pathology reports		RN/LPN/MTA									2				3			
34	End: Patient leaves office																		
35	POST-SERVICE Period																		
36	Start: Patient leaves office/facility																		
37	Conduct phone calls/call in prescriptions																		
38	*Office visits: List Number and Level of Office Visits*					# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
39	Discharge day mgmt - same day (eg, 0.5 x 99238)	RN/LPN/MTA	6			n/a				n/a				n/a				n/a	
40	Discharge day mgmt - 99238		12			n/a				n/a				n/a				n/a	
41	Discharge day mgmt - 99239		15			n/a				n/a				n/a				n/a	
42	99211 16 minutes		16																
43	99212 27 minutes		27																
44	99213 36 minutes		36																
45	99214 53 minutes		53																
46	99215 63 minutes		63																
47	Total Office Visit Time																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11300		CPT Code # 11300		CPT Code # 11301		CPT Code # 11301		CPT Code # 11302		CPT Code # 11302		CPT Code # 11303		CPT Code # 11303	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
48	Other Clinical Activity - *specify:*																		
49	**End: with last office visit before end of global period**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11300		CPT Code # 11300		CPT Code # 11301		CPT Code # 11301		CPT Code # 11302		CPT Code # 11302		CPT Code # 11303		CPT Code # 11303	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
50	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																
51	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1	
52	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item	1		1		1		1		1		1		1		1	
53	mask, surgical, with face shield	SB033	item	2		1		2		1		2		1		2		1	
54	gown, staff, impervious	SB027	item	1		1				1		2		1		2		1	
55	gown, patient	SB026	item			0				0				0				0	
56	cap, surgical	SB001	item			2				2				2				2	
57	gloves, non-sterile, nitrile	SB023	pair			1				1				1				1	
58	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2	
59	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1				1				1	
60	drape, sterile, for Mayo stand	SB012	item			1				1				1				1	
61	drape-cover, sterile, OR light handle	SB016	item			1				1				1				1	
62	povidone surgical scrub (Betadine)	SJ041	ml	10		10		10		10		10		10		10		10	
63	swab-pad, alcohol	SJ053	item	1		2		1		2		1		2		1		2	
64	syringe-needle 3ml 22-26g	SC064	item	1		1		1		1		1		2		1		2	
65	needle, 18-27g	SC029	item			0				0				0				0	
66	needle, 30g	SC031	item			1				1				2				2	
67	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		4cc		10		4cc		10		8cc		10		8cc	
68	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1		1		2		1		2	
69	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		1		3		1		4	
70	drape-towel, sterile OR blue (2 pk uou)	SB020	item			2				2				2				2	
71	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			1				1				1				1	
72	cover, probe (electrocautery)	SB003	item			0				0				0				0	
73	cautery, monopolar, electrode tip	SF016	item			0				0		1		0		1		0	
74	tape, surgical paper 1in (Micropore)	SG079	inch	12		6		12		12		12		18		12		24	
75	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1		1		2	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		1		1		1		1		1		1	
77	cotton balls, non-sterile	SG030	item			4				4				4				4	
78	dressing, 4in x 4in (Vigilon)	SG038	item											1				1	
79	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1				1				1	
80	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3				3				3	
81	dressing - gelfoam	SG033	item	1				1				1				1			
82	applicator, cotton-tipped, sterile, 6in	SG081	item			6				8				10				12	
83	aluminum chloride 70% solution - Not on CMS List, Inv Reqd.		item			2				4				6		1		8	
84	pack, cleaning, surgical instruments	SA043	pack			1				1				1				1	
85	hydrogen peroxide	SJ028	ml	20				20				20				20			
86	**EQUIPMENT**	**CODE**																	
87	light, surgical	EF014				14				17				20				22	
88	mayo stand	EF015				14				17				20				22	
89	electrocautery-hyfrecator, up to 45 watts	EQ110				0				0		1		0		1		0	
90	table, power	EF031		1		14		1		17		1		20		1		22	
91	instrument pack, basic ($500-$1499)	EQ137				24				27				30				32	
92	camera, digital (6 mexapixel)	ED004				14				17				20				22	
93	Smoke Evacuator (tubing, covering, etc.) with stand	EQ351				14				17				20				22	

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11305		CPT Code # 11305		CPT Code # 11306		CPT Code # 11306		CPT Code # 11307		CPT Code # 11307		CPT Code # 11308		CPT Code # 11308	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**					0				0				0				0	
6	**TOTAL CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**			**27.0**	**0.0**			**35.0**	**0.0**			**31.0**	**0.0**			**34.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**22.0**	**0.0**	**27.0**	**0.0**	**29.0**	**0.0**	**35.0**	**0.0**	**34.0**	**0.0**	**31.0**	**0.0**	**41.0**	**0.0**	**34.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**																		
11	**Start: Following visit when decision for surgery or procedure made**																		
12	Complete pre-service diagnostic & referral forms		**RN/LPN/MTA**																
13	Coordinate pre-surgery services		**RN/LPN/MTA**																
14	Schedule space and equipment in facility		**RN/LPN/MTA**																
15	Provide pre-service education/obtain consent		**RN/LPN/MTA**																
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - *specify:*																		
18	**End: When patient enters office/facility for surgery/procedure**																		
19	**SERVICE PERIOD**																		
20	**Start: When patient enters office/facility for surgery/procedure:**																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		**RN/LPN/MTA**	3				3				3				3			
22	Obtain vital signs		**RN/LPN/MTA**	3				3				3				3			
23	Provide pre-service education/obtain consent		**RN/LPN/MTA**	2				2				2				2			
24	Prepare room, equipment, supplies		**RN/LPN/MTA**	2		2		2		2		2		2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV		**RN/LPN/MTA**	3		3		3		3		3		3		3		3	
26	**Intra-service**																		
27	Assist physician in performing procedure		**RN/LPN/MTA**	8		10		11		18		14		14		19		17	
28	**Post-Service**																		
29	Clean room/equipment by physician staff		**RN/LPN/MTA**	1				1				1				2			
30	Complete diagnostic forms, lab & X-ray requisitions		**RN/LPN/MTA**			2		2		2		2		2		2		2	
31	Clean Surgical Instrument Package		**RN/LPN/MTA**			10				10				10				10	
32	Complete diagnostic forms, lab & X-ray requisitions		**RN/LPN/MTA**					2				2				2			
33	Review/read X-ray, lab, and pathology reports		**RN/LPN/MTA**									2				3			
34	**End: Patient leaves office**																		
35	**POST-SERVICE Period**																		
36	**Start: Patient leaves office/facility**																		
37	Conduct phone calls/call in prescriptions																		
38	***Office visits: List Number and Level of Office Visits***					**# visits**	**# visits**			**# visits**	**# visits**			**# visits**	**# visits**			**# visits**	**# visits**
39	Discharge day mgmt - same day (eg, 0.5 x 99238)	**RN/LPN/MTA**	6			**n/a**				**n/a**				**n/a**				**n/a**	
40	Discharge day mgmt - 99238		12			**n/a**				**n/a**				**n/a**				**n/a**	
41	Discharge day mgmt - 99239		15			**n/a**				**n/a**				**n/a**				**n/a**	
42	99211 16 minutes		16																
43	99212 27 minutes		27																
44	99213 36 minutes		36																
45	99214 53 minutes		53																
46	99215 63 minutes		63																
47	**Total Office Visit Time**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11305		CPT Code # 11305		CPT Code # 11306		CPT Code # 11306		CPT Code # 11307		CPT Code # 11307		CPT Code # 11308		CPT Code # 11308	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**
48	Other Clinical Activity - *specify:*																		
49	**End: with last office visit before end of global period**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11305		CPT Code # 11305		CPT Code # 11306		CPT Code # 11306		CPT Code # 11307		CPT Code # 11307		CPT Code # 11308		CPT Code # 11308	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**
50	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																
51	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1	
52	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item	1		1		1		1		1		1		1		1	
53	mask, surgical, with face shield	SB033	item	2		1		2		1		2		1		2		1	
54	gown, staff, impervious	SB027	item	1		1		1		1		2		1		2		1	
55	gown, patient	SB026	item			0				0				0				0	
56	cap, surgical	SB001	item			2				2				2				2	
57	gloves, non-sterile, nitrile	SB023	pair			1				1				1				1	
58	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2	
59	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1				1				1	
60	drape, sterile, for Mayo stand	SB012	item			1				1				1				1	
61	drape-cover, sterile, OR light handle	SB016	item			1				1				1				1	
62	povidone surgical scrub (Betadine)	SJ041	ml	10		10		10		10		10		10		10		10	
63	swab-pad, alcohol	SJ053	item	1		2		1		2		1		2		1		2	
64	syringe-needle 3ml 22-26g	SC064	item	1		1		1		1				2		1		2	
65	needle, 18-27g	SC029	item			0				0				0				0	
66	needle, 30g	SC031	item			1				2				2				2	
67	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		4cc		10		4cc		10		8cc		10		8cc	
68	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1		1		2		1		2	
69	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		1		3		1		4	
70	drape-towel, sterile OR blue (2 pk uou)	SB020	item			2				2				2				2	
71	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			1				1				1				1	
72	cover, probe (electrocautery)	SB003	item			0				0				0				0	
73	cautery, monopolar, electrode tip	SF016	item			0				0		1		0		1		0	
74	tape, surgical paper 1in (Micropore)	SG079	inch	12		6		12		12		12		18		12		24	
75	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1		1		2	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		1		1		1		1		1		1	
77	cotton balls, non-sterile	SG030	item			4				4				4				4	
78	dressing, 4in x 4in (Vigilon)	SG038	item											1				1	
79	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1				1				1	
80	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3				3				3	
81	dressing - gelfoam	SG033	item	1				1				1				1			
82	applicator, cotton-tipped, sterile, 6in	SG081	item			6				8				10				12	
83	aluminum chloride 70% solution - Not on CMS List, Inv Reqd.		item			2				4		1		6		1		8	
84	pack, cleaning, surgical instruments	SA043	pack			1				1				1				1	
85	hydrogen peroxide	SJ028	ml	20				20				20				20			
86	**EQUIPMENT**	**CODE**																	
87	light, surgical	EF014				17				17				21				24	
88	mayo stand	EF015				17				17				21				24	
89	electrocautery-hyfrecator, up to 45 watts	EQ110				17				0		1		0		1		0	
90	table, power	EF031		1		17		1		17		1		21		1		24	
91	instrument pack, basic ($500-$1499)	EQ137				27				27				31				34	
92	camera, digital (6 mexapixel)	ED004				17				17				21				24	
93	Smoke Evacuator (tubing, covering, etc.) with stand	EQ351				17				17				21				24	

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11310		CPT Code # 11310		CPT Code # 11311		CPT Code # 11311		CPT Code # 11312		CPT Code # 11312		CPT Code # 11313		CPT Code # 11313	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**					0				0				0				0	
6	**TOTAL CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**			**30.0**	**0.0**			**28.0**	**0.0**			**37.0**	**0.0**			**40.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**24.0**	**0.0**	**30.0**	**0.0**	**28.0**	**0.0**	**28.0**	**0.0**	**36.0**	**0.0**	**37.0**	**0.0**	**44.0**	**0.0**	**40.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**																		
11	**Start: Following visit when decision for surgery or procedure made**																		
12	Complete pre-service diagnostic & referral forms		**RN/LPN/MTA**																
13	Coordinate pre-surgery services		**RN/LPN/MTA**																
14	Schedule space and equipment in facility		**RN/LPN/MTA**																
15	Provide pre-service education/obtain consent		**RN/LPN/MTA**																
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - *specify:*																		
18	**End: When patient enters office/facility for surgery/procedure**																		
19	**SERVICE PERIOD**																		
20	**Start: When patient enters office/facility for surgery/procedure:**																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		**RN/LPN/MTA**	3				3				3				3			
22	Obtain vital signs		**RN/LPN/MTA**	3				3				3				3			
23	Provide pre-service education/obtain consent		**RN/LPN/MTA**	2				2				2				2			
24	Prepare room, equipment, supplies		**RN/LPN/MTA**	2		2		2		2		2		2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV		**RN/LPN/MTA**	3		3		3		3		3		3		3		3	
26	**Intra-service**																		
27	Assist physician in performing procedure		**RN/LPN/MTA**	10		13		10		11		16		20		22		23	
28	**Post-Service**																		
29	Clean room/equipment by physician staff		**RN/LPN/MTA**	1				1				1				2			
30	Complete diagnostic forms, lab & X-ray requisitions		**RN/LPN/MTA**			2		2		2		2		2		2		2	
31	Clean Surgical Instrument Package		**RN/LPN/MTA**			10				10				10				**10**	
32	Complete diagnostic forms, lab & X-ray requisitions		**RN/LPN/MTA**					2				2				2			
33	Review/read X-ray, lab, and pathology reports		**RN/LPN/MTA**									2				3			
34	**End: Patient leaves office**																		
35	**POST-SERVICE Period**																		
36	**Start: Patient leaves office/facility**																		
37	Conduct phone calls/call in prescriptions																		
38	***Office visits: List Number and Level of Office Visits***					**# visits**	**# visits**			**# visits**	**# visits**			**# visits**	**# visits**			**# visits**	**# visits**
39	Discharge day mgmt - same day (eg, 0.5 x 99238)	**RN/LPN/MTA**	6			**n/a**				**n/a**				**n/a**				**n/a**	
40	Discharge day mgmt - 99238		12			**n/a**				**n/a**				**n/a**				**n/a**	
41	Discharge day mgmt - 99239		15			**n/a**				**n/a**				**n/a**				**n/a**	
42	99211 16 minutes		16																
43	99212 27 minutes		27																
44	99213 36 minutes		36																
45	99214 53 minutes		53																
46	99215 63 minutes		63																
47	**Total Office Visit Time**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11310		CPT Code # 11310		CPT Code # 11311		CPT Code # 11311		CPT Code # 11312		CPT Code # 11312		CPT Code # 11313		CPT Code # 11313	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**			**Non Fac**	**Facility**
48	Other Clinical Activity - *specify:*																		
49	**End: with last office visit before end of global period**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11310		CPT Code # 11310		CPT Code # 11311		CPT Code # 11311		CPT Code # 11312		CPT Code # 11312		CPT Code # 11313		CPT Code # 11313	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**			**Non Fac**	**Facility**
50	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																
51	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1	
52	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item	1		1		1		1		1		1		1		1	
53	mask, surgical, with face shield	SB033	item	2		1		2		1		2		1		2		1	
54	gown, staff, impervious	SB027	item	1		1		1		1		2		1		2		1	
55	gown, patient	SB026	item			0				0				0				0	
56	cap, surgical	SB001	item			2				2				2				2	
57	gloves, non-sterile, nitrile	SB023	pair			1				1				1				1	
58	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2	
59	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1				1				1	
60	drape, sterile, for Mayo stand	SB012	item			1				1				1				1	
61	drape-cover, sterile, OR light handle	SB016	item			1				1				1				1	
62	povidone surgical scrub (Betadine)	SJ041	ml	10		10		10		10		10		10		10		10	
63	swab-pad, alcohol	SJ053	item	1		2		1		2		1		2		1		2	
64	syringe-needle 3ml 22-26g	SC064	item	1		1		1		1		1		2		1		2	
65	needle, 18-27g	SC029	item			0				0				0				0	
66	needle, 30g	SC031	item			1				1				2				2	
67	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		4cc		10		4cc		10		8cc		10		8cc	
68	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1		1		2		1		2	
69	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		1		3		1		4	
70	drape-towel, sterile OR blue (2 pk uou)	SB020	item			2				2				2				2	
71	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			1				1				1				1	
72	cover, probe (electrocautery)	SB003	item			0				0				0				0	
73	cautery, monopolar, electrode tip	SF016	item			0				0		1		0		1		0	
74	tape, surgical paper 1in (Micropore)	SG079	inch	12		6		12		12		12		18		12		24	
75	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1		1		2	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		1		1		1		1		1		1	
77	cotton balls, non-sterile	SG030	item			4				4				4				4	
78	dressing, 4in x 4in (Vigilon)	SG038	item											1				1	
79	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1				1				1	
80	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3				3				3	
81	dressing - gelfoam	SG033	item	1				1				1				1			
82	applicator, cotton-tipped, sterile, 6in	SG081	item			6				8				10				12	
83	aluminum chloride 70% solution - Not on CMS List, Inv Reqd.		item			2				4		1		6		1		8	
84	pack, cleaning, surgical instruments	SA043	pack			1				1				1				1	
85	hydrogen peroxide	SJ028	ml	20				20				20				20			
86	**EQUIPMENT**	**CODE**																	
87	light, surgical	EF014				20				18				17				30	
88	mayo stand	EF015				20				18				17				30	
89	electrocautery-hyfrecator, up to 45 watts	EQ110				0				0		1		0		1		0	
90	table, power	EF031		1		20		1		18		1		17		1		30	
91	instrument pack, basic ($500-$1499)	EQ137				30				28				37				40	
92	camera, digital (6 mexapixel)	ED004				20				18				17				30	
93	Smoke Evacuator (tubing, covering, etc.) with stand	EQ351				20				18				17				30	

AMA/Specialty Society RVS Update Committee Recommendation

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1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11300		CPT Code # 11300		CPT Code # 11301		CPT Code # 11301		CPT Code # 11302		CPT Code # 11302		CPT Code # 11303		CPT Code # 11303	
3	Meeting Date: April 2012	CMS Code	Staff Type	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			0		0		0		0				0				0	
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	21.0	0.0	15.0	0.0			18.0	0.0			21.0	0.0			24.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	21.0	0.0	15.0	0.0	27.0	0.0	18.0	0.0	32.0	0.0	21.0	0.0	47.0	0.0	24.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE																		
11	Start: Following visit when decision for surgery or procedure made																		
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA																
13	Coordinate pre-surgery services		RN/LPN/MTA																
14	Schedule space and equipment in facility		RN/LPN/MTA																
15	Provide pre-service education/obtain consent		RN/LPN/MTA																
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - *specify:*																		
18	End: When patient enters office/facility for surgery/procedure																		
19	SERVICE PERIOD																		
20	Start: When patient enters office/facility for surgery/procedure:																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		RN/LPN/MTA	3				3				3				3			
22	Obtain vital signs		RN/LPN/MTA	3				3				3				3			
23	Provide pre-service education/obtain consent		RN/LPN/MTA	2				2				2				2			
24	Prepare room, equipment, supplies		RN/LPN/MTA	2		2		2		2		2		2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV		RN/LPN/MTA	3		3		3		3		3		3		3		3	
26	Intra-service																		
27	Assist physician in performing procedure		RN/LPN/MTA	7		7		9		10		12		13		25		15	
28	Post-Service																		
29	Clean room/equipment by physician staff		RN/LPN/MTA	1				1				1				2			
30	Complete diagnostic forms, lab & X-ray requisitions		RN/LPN/MTA			2		2		2		2		2		2		2	
31	Clean Surgical Instrument Package		RN/LPN/MTA			1				1				1				2	
32	Complete diagnostic forms, lab & X-ray requisitions		RN/LPN/MTA					2				2				2			
33	Review/read X-ray, lab, and pathology reports		RN/LPN/MTA									2				3			
34	End: Patient leaves office																		
35	POST-SERVICE Period																		
36	Start: Patient leaves office/facility																		
37	Conduct phone calls/call in prescriptions																		
38	*Office visits: List Number and Level of Office Visits*					# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
39	Discharge day mgmt - same day (eg, 0.5 x 99238)	RN/LPN/MTA	6			n/a				n/a				n/a				n/a	
40	Discharge day mgmt - 99238		12			n/a				n/a				n/a				n/a	
41	Discharge day mgmt - 99239		15			n/a				n/a				n/a				n/a	
42	99211 16 minutes		16																
43	99212 27 minutes		27																
44	99213 36 minutes		36																
45	99214 53 minutes		53																
46	99215 63 minutes		63																
47	Total Office Visit Time																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11300		CPT Code # 11300		CPT Code # 11301		CPT Code # 11301		CPT Code # 11302		CPT Code # 11302		CPT Code # 11303		CPT Code # 11303	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
48	Other Clinical Activity - *specify:*																		
49	**End: with last office visit before end of global period**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11300		CPT Code # 11300		CPT Code # 11301		CPT Code # 11301		CPT Code # 11302		CPT Code # 11302		CPT Code # 11303		CPT Code # 11303	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
50	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																
51	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1	
52	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item	1		1		1		1		1		1		1		1	
53	mask, surgical, with face shield	SB033	item	2		2		2		2		2		2		2		2	
54	gown, staff, impervious	SB027	item	1		2				2		2		2		2		2	
55	gown, patient	SB026	item			0				0				0				0	
56	cap, surgical	SB001	item			2				2				2				2	
57	gloves, non-sterile, nitrile	SB023	pair			1				1				1				1	
58	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2	
59	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1				1				1	
60	drape, sterile, for Mayo stand	SB012	item			1				1				1				1	
61	drape-cover, sterile, OR light handle	SB016	item			1				1				1				1	
62	povidone surgical scrub (Betadine)	SJ041	ml	10		10		10		10		10		10		10		10	
63	swab-pad, alcohol	SJ053	item	1		2		1		2		1		2		1		2	
64	syringe-needle 3ml 22-26g	SC064	item	1		1		1		1		1		2		1		2	
65	needle, 18-27g	SC029	item			1				1				1				1	
66	needle, 30g	SC031	item			1				1				2				2	
67	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		4cc		10		4cc		10		8cc		10		8cc	
68	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1		1		2		1		2	
69	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		1		3		1		4	
70	drape-towel, sterile OR blue (2 pk uou)	SB020	item			2				2				2				2	
71	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			1				1				1				1	
72	cover, probe (electrocautery)	SB003	item			1				1				1				1	
73	cautery, monopolar, electrode tip	SF016	item			0				0		1		0		1		0	
74	tape, surgical paper 1in (Micropore)	SG079	inch	12		6		12		12		12		18		12		24	
75	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1		1		2	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		1		1		1		1		1		1	
77	cotton balls, non-sterile	SG030	item			4				4				4				4	
78	dressing, 4in x 4in (Vigilon)	SG038	item											1				1	
79	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1				1				1	
80	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3				3				3	
81	dressing - gelfoam	SG033	item	1				1				1				1			
82	applicator, cotton-tipped, sterile, 6in	SG081	item			6				8				10				12	
83	aluminum chloride 70% solution - Not on CMS List, Inv Reqd.		item			2				4				6		1		8	
84	pack, cleaning, surgical instruments	SA043	pack			1				1				1				1	
85	hydrogen peroxide	SJ028	ml	20				20				20				20			
86	**EQUIPMENT**	**CODE**																	
87	light, surgical	EF014				29				32				37				41	
88	mayo stand	EF015				29				32				37				41	
89	electrocautery-hyfrecator, up to 45 watts	EQ110				29				32		1		37		1		41	
90	table, power	EF031		1		29		1		32		1		37		1		41	
91	instrument pack, basic ($500-$1499)	EQ137				29				32				37				41	
92	camera, digital (6 mexapixel)	ED004				29				32				37				41	
93	*Smoke evacuator* *Invoice to be supplied*					29				32				37				41	

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	A	B	C	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11305		CPT Code # 11305		CPT Code # 11306		CPT Code # 11306		CPT Code # 11307		CPT Code # 11307		CPT Code # 11308		CPT Code # 11308	
3	Meeting Date: April 2012	CMS Code	Staff Type	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility			Non Fac	Facility
5	GLOBAL PERIOD					0				0				0				0	
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA			18.0	0.0			18.0	0.0			22.0	0.0			26.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	22.0	0.0	18.0	0.0	29.0	0.0	18.0	0.0	34.0	0.0	22.0	0.0	41.0	0.0	26.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE																		
11	Start: Following visit when decision for surgery or procedure made																		
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA																
13	Coordinate pre-surgery services		RN/LPN/MTA																
14	Schedule space and equipment in facility		RN/LPN/MTA																
15	Provide pre-service education/obtain consent		RN/LPN/MTA																
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - *specify:*																		
18	End: When patient enters office/facility for surgery/procedure																		
19	SERVICE PERIOD																		
20	Start: When patient enters office/facility for surgery/procedure:																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		RN/LPN/MTA	3				3				3				3			
22	Obtain vital signs		RN/LPN/MTA	3				3				3				3			
23	Provide pre-service education/obtain consent		RN/LPN/MTA	2				2				2				2			
24	Prepare room, equipment, supplies		RN/LPN/MTA	2		2		2		2		2		2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV		RN/LPN/MTA	3		3		3		3		3		3		3		3	
26	Intra-service																		
27	Assist physician in performing procedure		RN/LPN/MTA	8		10		11		10		14		14		19		17	
28	Post-Service																		
29	Clean room/equipment by physician staff		RN/LPN/MTA	1				1				1				2			
30	Complete diagnostic forms, lab & X-ray requisitions		RN/LPN/MTA			2		2		2		2		2		2		2	
31	Clean Surgical Instrument Package		RN/LPN/MTA			1				1				1				2	
32	Complete diagnostic forms, lab & X-ray requisitions		RN/LPN/MTA					2				2				2			
33	Review/read X-ray, lab, and pathology reports		RN/LPN/MTA									2				3			
34	End: Patient leaves office																		
35	POST-SERVICE Period																		
36	Start: Patient leaves office/facility																		
37	Conduct phone calls/call in prescriptions																		
38	*Office visits: List Number and Level of Office Visits*					# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
39	Discharge day mgmt - same day (eg, 0.5 x 99238)	RN/LPN/MTA	6			n/a				n/a				n/a				n/a	
40	Discharge day mgmt - 99238		12			n/a				n/a				n/a				n/a	
41	Discharge day mgmt - 99239		15			n/a				n/a				n/a				n/a	
42	99211 16 minutes		16																
43	99212 27 minutes		27																
44	99213 36 minutes		36																
45	99214 53 minutes		53																
46	99215 63 minutes		63																
47	Total Office Visit Time																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11305		CPT Code # 11305		CPT Code # 11306		CPT Code # 11306		CPT Code # 11307		CPT Code # 11307		CPT Code # 11308		CPT Code # 11308	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**
48	Other Clinical Activity - *specify:*																		
49	**End: with last office visit before end of global period**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11305		CPT Code # 11305		CPT Code # 11306		CPT Code # 11306		CPT Code # 11307		CPT Code # 11307		CPT Code # 11308		CPT Code # 11308	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**
50	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																
51	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1	
52	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item	1		1		1		1		1		1		1		1	
53	mask, surgical, with face shield	SB033	item	2		2		2		2		2		2		2		2	
54	gown, staff, impervious	SB027	item	1		2		1		2		2		2		2		2	
55	gown, patient	SB026	item			0				0				0				0	
56	cap, surgical	SB001	item			2				2				2				2	
57	gloves, non-sterile, nitrile	SB023	pair			1				1				1				1	
58	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2	
59	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1				1				1	
60	drape, sterile, for Mayo stand	SB012	item			1				1				1				1	
61	drape-cover, sterile, OR light handle	SB016	item			1				1				1				1	
62	povidone surgical scrub (Betadine)	SJ041	ml	10		10		10		10		10		10		10		10	
63	swab-pad, alcohol	SJ053	item	1		2		1		2		1		2		1		2	
64	syringe-needle 3ml 22-26g	SC064	item	1		1		1		1				2		1		2	
65	needle, 18-27g	SC029	item			1				2				2				2	
66	needle, 30g	SC031	item			1				2				2				2	
67	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		4cc		10		4cc		10		8cc		10		8cc	
68	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1		1		2		1		2	
69	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		1		3		1		4	
70	drape-towel, sterile OR blue (2 pk uou)	SB020	item			2				2				2				2	
71	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			1				1				1				1	
72	cover, probe (electrocautery)	SB003	item			1				1				1				1	
73	cautery, monopolar, electrode tip	SF016	item			0				0		1		0		1		0	
74	tape, surgical paper 1in (Micropore)	SG079	inch	12		6		12		12		12		18		12		24	
75	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1		1		2	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		1		1		1		1		1		1	
77	cotton balls, non-sterile	SG030	item			4				4				4				4	
78	dressing, 4in x 4in (Vigilon)	SG038	item											1				1	
79	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1				1				1	
80	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3				3				3	
81	dressing - gelfoam	SG033	item	1				1				1				1			
82	applicator, cotton-tipped, sterile, 6in	SG081	item			6				8				10				12	
83	aluminum chloride 70% solution - Not on CMS List, Inv Reqd.		item			2				4		1		6		1		8	
84	pack, cleaning, surgical instruments	SA043	pack			1				1				1				1	
85	hydrogen peroxide	SJ028	ml	20				20				20				20			
86	**EQUIPMENT**	**CODE**																	
87	light, surgical	EF014				29				31				37				42	
88	mayo stand	EF015				29				31				37				42	
89	electrocautery-hyfrecator, up to 45 watts	EQ110				29				31		1		37		1		42	
90	table, power	EF031		1		29		1		31		1		37		1		42	
91	instrument pack, basic ($500-$1499)	EQ137				29				31				37				42	
92	camera, digital (6 mexapixel)	ED004				29				31				37				42	
93	*Smoke evacuator* *Invoice to be supplied*					29				31				37				42	

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11310		CPT Code # 11310		CPT Code # 11311		CPT Code # 11311		CPT Code # 11312		CPT Code # 11312		CPT Code # 11313		CPT Code # 11313	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**			**Non Fac**	**Facility**
5	**GLOBAL PERIOD**					0				0				0				0	
6	**TOTAL CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**			**21.0**	**0.0**			**19.0**	**0.0**			**28.0**	**0.0**			**32.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**24.0**	**0.0**	**21.0**	**0.0**	**28.0**	**0.0**	**19.0**	**0.0**	**36.0**	**0.0**	**28.0**	**0.0**	**44.0**	**0.0**	**32.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**																		
11	**Start: Following visit when decision for surgery or procedure made**																		
12	Complete pre-service diagnostic & referral forms		**RN/LPN/MTA**																
13	Coordinate pre-surgery services		**RN/LPN/MTA**																
14	Schedule space and equipment in facility		**RN/LPN/MTA**																
15	Provide pre-service education/obtain consent		**RN/LPN/MTA**																
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - *specify:*																		
18	**End: When patient enters office/facility for surgery/procedure**																		
19	**SERVICE PERIOD**																		
20	**Start: When patient enters office/facility for surgery/procedure:**																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		**RN/LPN/MTA**	3				3				3				3			
22	Obtain vital signs		**RN/LPN/MTA**	3				3				3				3			
23	Provide pre-service education/obtain consent		**RN/LPN/MTA**	2				2				2				2			
24	Prepare room, equipment, supplies		**RN/LPN/MTA**	2		2		2		2		2		2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV		**RN/LPN/MTA**	3		3		3		3		3		3		3		3	
26	**Intra-service**																		
27	Assist physician in performing procedure		**RN/LPN/MTA**	10		13		10		11		16		20		22		23	
28	**Post-Service**																		
29	Clean room/equipment by physician staff		**RN/LPN/MTA**	1				1				1				2			
30	Complete diagnostic forms, lab & X-ray requisitions		**RN/LPN/MTA**			2		2		2		2		2		2		2	
31	Clean Surgical Instrument Package		**RN/LPN/MTA**			1				1				1				**2**	
32	Complete diagnostic forms, lab & X-ray requisitions		**RN/LPN/MTA**					2				2				2			
33	Review/read X-ray, lab, and pathology reports		**RN/LPN/MTA**									2				3			
34	**End: Patient leaves office**																		
35	**POST-SERVICE Period**																		
36	**Start: Patient leaves office/facility**																		
37	Conduct phone calls/call in prescriptions																		
38	***Office visits: List Number and Level of Office Visits***					**# visits**	**# visits**			**# visits**	**# visits**			**# visits**	**# visits**			**# visits**	**# visits**
39	Discharge day mgmt - same day (eg, 0.5 x 99238)	**RN/LPN/MTA**	6			**n/a**				**n/a**				**n/a**				**n/a**	
40	Discharge day mgmt - 99238		12			**n/a**				**n/a**				**n/a**				**n/a**	
41	Discharge day mgmt - 99239		15			**n/a**				**n/a**				**n/a**				**n/a**	
42	99211 16 minutes		16																
43	99212 27 minutes		27																
44	99213 36 minutes		36																
45	99214 53 minutes		53																
46	99215 63 minutes		63																
47	**Total Office Visit Time**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11310		CPT Code # 11310		CPT Code # 11311		CPT Code # 11311		CPT Code # 11312		CPT Code # 11312		CPT Code # 11313		CPT Code # 11313	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**			**Non Fac**	**Facility**
48	Other Clinical Activity - *specify:*																		
49	**End: with last office visit before end of global period**																		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				CPT Code # 11310		CPT Code # 11310		CPT Code # 11311		CPT Code # 11311		CPT Code # 11312		CPT Code # 11312		CPT Code # 11313		CPT Code # 11313	
3	**Meeting Date: April 2012**	**CMS Code**	**Staff Type**	**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**		**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**			**Non Fac**	**Facility**			**Non Fac**	**Facility**
50	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																
51	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1	
52	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item	1		1		1		1		1		1		1		1	
53	mask, surgical, with face shield	SB033	item	2		2		2		2		2		2		2		2	
54	gown, staff, impervious	SB027	item	1		2		1		2		2		2		2		2	
55	gown, patient	SB026	item			0				0				0				0	
56	cap, surgical	SB001	item			2				2				2				2	
57	gloves, non-sterile, nitrile	SB023	pair			1				1				1				1	
58	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2	
59	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1				1				1	
60	drape, sterile, for Mayo stand	SB012	item			1				1				1				1	
61	drape-cover, sterile, OR light handle	SB016	item			1				1				1				1	
62	povidone surgical scrub (Betadine)	SJ041	ml	10		10		10		10		10		10		10		10	
63	swab-pad, alcohol	SJ053	item	1		2		1		2		1		2		1		2	
64	syringe-needle 3ml 22-26g	SC064	item	1		1		1		1		1		2		1		2	
65	needle, 18-27g	SC029	item			1				1				2				2	
66	needle, 30g	SC031	item			1				1				2				2	
67	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		4cc		10		4cc		10		8cc		10		8cc	
68	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1		1		2		1		2	
69	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		1		3		1		4	
70	drape-towel, sterile OR blue (2 pk uou)	SB020	item			2				2				2				2	
71	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			1				1				1				1	
72	cover, probe (electrocautery)	SB003	item			1				1				1				1	
73	cautery, monopolar, electrode tip	SF016	item			0				0		1		0		1		0	
74	tape, surgical paper 1in (Micropore)	SG079	inch	12		6		12		12		12		18		12		24	
75	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1		1		2	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		1		1		1		1		1		1	
77	cotton balls, non-sterile	SG030	item			4				4				4				4	
78	dressing, 4in x 4in (Vigilon)	SG038	item											1				1	
79	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1				1				1	
80	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3				3				3	
81	dressing - gelfoam	SG033	item	1				1				1				1			
82	applicator, cotton-tipped, sterile, 6in	SG081	item			6				8				10				12	
83	aluminum chloride 70% solution - Not on CMS List, Inv Reqd.		item			2				4		1		6		1		8	
84	pack, cleaning, surgical instruments	SA043	pack			1				1				1				1	
85	hydrogen peroxide	SJ028	ml	20				20				20				20			
86	**EQUIPMENT**	**CODE**																	
87	light, surgical	EF014				34				34				43				48	
88	mayo stand	EF015				34				34				43				48	
89	electrocautery-hyfrecator, up to 45 watts	EQ110				34				34		1		43		1		48	
90	table, power	EF031		1		34		1		34		1		43		1		48	
91	instrument pack, basic ($500-$1499)	EQ137				34				34				43				48	
92	camera, digital (6 mexapixel)	ED004				34				34				43				48	
93	*Smoke evacuator* *Invoice to be supplied*					34				34				43				48	

AMA/Specialty Society RVS Update RUC Summary of Recommendations
CMS Request - NPRM for 2012

April 2012

Complex Wound Repair

In April 2011, the RUC identified codes 13131 and 13152 as part of the Harvard Valued – Utilization Over 30,000 screen for survey at the September 2011 meeting. CPT codes 13100 and 13101 were reviewed as part of the 4th Five-Year Review. However, in the June 6, 2011 *Proposed Rule* for the 4th Five-Year Review of the RBRVS, CMS requested that the RUC review the entire family of complex wound repair codes to ensure consistency and appropriate gradation of work value. The RUC recommended that the specialty society re-survey codes 13100-13152 for the April 2012 RUC meeting.

13100 Repair, complex, trunk; 1.1 cm to 2.5 cm
The RUC reviewed the survey results from 101 dermatologists and plastic surgeons for 13100 and recommends the survey 25th percentile work RVU of 3.00, which is lower than the current value. The RUC compared 13100, with 32 minutes of intra-service time to CPT codes 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU = 2.82 and intra-time = 30 minutes) and 11444 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm* (work RVU = 3.19 and intra-service time = 40 minutes), and determined that using magnitude estimation, the work required to perform 13100 is appropriately placed between these two services. The RUC determined that CPT code 13100 requires more physician time to perform to apply anesthesia to a larger area using a regional block, to undermine tissue and requires more cosmetic detail to repair compared to excision code 11603. **The RUC recommends a work RVU of 3.00 for CPT code 13100.**

13101 Repair, complex, trunk; 2.6 cm to 7.5 cm
The RUC reviewed the survey results from 95 dermatologists and plastic surgeons for 13101 and recommends the survey 25th percentile work RVU of 3.50, which is lower than the current value. The RUC determined that survey 25th percentile appropriately places this service in the proper rank order relative to code 13100 which requires 32 minutes of intra-service time compared to 45 minutes of intra-service time required to perform 13101, as well as accounts for the larger area repaired. For additional support the RUC compared 13101 to key reference service 12032 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm* (work RVU = 2.52 and 30 minutes intra-service time) and MPC code 11644 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm* (work RVU = 4.34 and 45 minutes intra-service time) and determined the physician work and time required to perform 13101 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 3.50 for CPT code 13101.**

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13102 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 128 dermatologists and plastic surgeons for 13102 and recommends the survey median intra-service time of 30 minutes and that the current work RVU of 1.24 be maintained. The RUC compared 13102 to key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73 and 40 minutes intra-service time) and MPC code 93563 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)* (work RVU = 1.11 and 25 minutes intra-service time) and determined that a work RVU of 1.24 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 1.24 for CPT code 13102.**

13120 Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
The RUC reviewed the survey results from 82 dermatologists and plastic surgeons for 13120 and recommends the survey median intra-service time of 35 minutes and survey 25th percentile work RVU of 3.23. The RUC compared 13120 to the recommended value for 13100 *Repair, complex, trunk; 1.1 cm to 2.5 cm* (recommended work RVU = 3.00 and 32 minutes intra-service time) and determined that 13120 requires slightly more intra-service time and it is more intense and complex to repair these body regions versus repairing a wound of the same size on the trunk. The RUC also compared 13120 to key reference service 12031 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less* (work RVU = 2.00 and 20 minutes intra-service time) and MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU = 3.42 and 30 minutes intra-service time) and determined that a work RVU of 3.23 appropriately places this service in the proper rank order. **The RUC recommends 3.23 work RVUs for CPT code 13120.**

13121 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
The RUC reviewed the survey results from 94 dermatologists and plastic surgeons for 13121 and recommends the survey intra-service time of 45 minutes and the survey 25th percentile work RVU of 4.00. The specialty society recommended and the RUC agreed that the intra-service time is 45 minutes and 1-99212 Office visit is typically required, not two as is currently included in this global period. Therefore, the decrease in work RVUs from the current work RVU of 4.42 is appropriate. The RUC also compared 13121 to CPT code 11010 *Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues* (work RVU = 4.19 and 50 minutes intra-service time) and MPC code 11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm (work RVU = 4.34 and 45 minutes intra-service time) and determined that a work RVU of 4.00 places this service in the proper rank order. **The RUC recommends a work RVU of 4.00 for CPT code 13121.**

13122 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 96 dermatologists and plastic surgeons for 13122 and recommends the survey median intra-service time of 30 minutes and that the current work RVU of 1.44 be maintained. The RUC compared 13122 to the recommended value for 13102 *Repair, complex, trunk; each additional 5 cm or less* (recommended work RVU = 1.24 and 30 minutes intra-service time) and determined that 13122 requires the same intra-service time, but is more intense and complex to repair these body regions versus repairing a wound of the same size on the

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trunk. The RUC also compared 13122 to key reference service 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73) and 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.00) and determined that the 13122 requires less physician work to perform. **The RUC recommends a work RVU of 1.44 for CPT code 13122.**

13131 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
The RUC reviewed the survey results from 87 dermatologists and plastic surgeons for 13131 and recommends the survey intra-service time of 45 minutes and the survey 25th percentile work RVU of 3.73. The RUC compared 13131 to the recommended value for 13120 *Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm* (recommended work RVU = 3.23 and 35 minutes intra-service time) and determined that 13131 requires 10 more intra-service time and it is more intense and complex to repair these body regions versus repairing a wound of the same size on the scalp, arms and/or legs. The RUC also compared 13131 to MPC code 11644 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm* (work RVU = 4.34 and intra-service time = 45 minutes) and determined that a work RVU of 3.73 places this service in the proper rank order. **The RUC recommends 3.73 work RVUs for CPT code 13131.**

13132 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
The RUC reviewed the survey results from 115 dermatologists and plastic surgeons for 13132 and recommends the survey 25th percentile work RVU of 4.78. The specialty society recommended and the RUC agreed that the intra-service time is 50 minutes and 1-99212 Office visit is typically required, not two as is currently included in this global period. Therefore, the decrease in work RVUs from the current work RVU of 6.58 is appropriate. The RUC also compared 13132 to similar service 11446 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm* (work RVU = 4.80 and 60 minutes intra-service time) and determined this a work RVU of 4.78 places this service in the proper rank order. **The RUC recommends a work RVU of 4.78 for CPT code 13132.**

13133 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 93 dermatologists and plastic surgeons for 13133 and recommends the survey median intra-service time of 35 minutes and that the survey 25th percentile work RVU of 2.19. The RUC compared 13133 to the recommended value for 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less* (recommended work RVU = 1.44 and 30 minutes intra-service time) and determined that 13133 requires more physician time to perform and is more intense and complex to repair these body regions versus repairing a wound of the same size on the scalp, arms and/or legs. The RUC also compared 13133 to 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.00 and 30 minutes intra-service time) and determined that 13133 requires more physician work and time to perform. **The RUC recommends a work RVU of 2.19 for CPT code 13133.**

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13150 Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
The RUC reveiwed the speiclaties request to delete CPT 13150. The RUC determined that the 1.0 cm or less size of this repair makes it a medically unlikely complex repair due to the small size of the repair. The specialty will submit a CPT proposal requesting deletion of this code for consideration at the October 2012 CPT meeting. **The RUC recommends deletion of CPT code 13150.**

13151 Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
The RUC reviewed the survey results from 144 dermatologists and plastic surgeons for CPT 13151 and determined that the survey 25th percentile work RVU of 3.50 was too low and would cause a rank order anomaly compared to less intense code 13131 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm* (recommended work RVU = 3.73). CPT code 13151 is more intense and complex to perform than 13131. CPT code 13151 has a higher risk of complication, requires finer smaller sutures in a delicate area, is more challenging to repair with underlying tissue planes and adjacent structures, has a more cosmetic impact and involves repair on mobile areas. Therefore, the RUC recommends a direct crosswalk to CPT code 11644 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm* (work RVU = 4.34 and intra-service time = 45 minutes) in order to maintain rank order among this family of services. **The RUC recommends a work RVU of 4.34 for CPT code 13151.**

13152 Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
The RUC reviewed the survey results from 107 dermatologists and plastic surgeons for CPT 13152 and determined that the survey 25th percentile work RVU of 4.90 was too low and would cause a rank order anomaly compared to less intense code 13132 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm* (recommended work RVU = 4.78). CPT code 13152 is more intense and complex to perform than 13132. CPT code 13152 has a higher risk of complication, requires finer smaller sutures in a delicate area, is more challenging to repair with underlying tissue planes and adjacent structures, has a more cosmetic impact and involves repair on mobile areas. Therefore, the RUC recommends a direct crosswalk to CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU = 5.34 and intra-service time = 50 minutes) in order to maintain rank order among this family of services. **The RUC recommends a work RVU of 5.34 for CPT code 13152.**

13153 Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 92 dermatologists and plastic surgeons for CPT 13153 and determined that the survey 25th percentile work RVU of 2.20 too low and would cause a rank order anomaly compared 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (recommended work RVU = 2.19 and intra-service time 35 minutes), which is less intense and requires 10 minutes less intra-service time to perform. The RUC compared 13153 to key reference service 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73 and 40 minutes intra-service time) and similar service 22116 *Partial excision of vertebral body, for intrinsic bony lesion, without*

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decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) (work RVU = 2.32 and 45 minutes intra-service time) and determined that a work RVU of 2.38 places this service in the proper rank order. **The RUC recommends the survey median and current RVU of 2.38 for CPT code 13153.**

CPT Code	Pre-Eval	Pre-Posit	Pre-SDW	Intra	Imm Post	Survey Value	Rec wRVU
Trunk							
13100	10	5	5	32	10	25th	3.00
13101	5	5	5	45	11	25th	3.50
13102	0	0	0	30	0	Maintain	1.24
Scalp, arms, and/or legs							
13120	14	5	5	35	10	25th	3.23
13121	16	5	5	45	10	25th	4.00
13122	0	0	0	30	0	Maintain	1.44
Eyelids, nose, ears and/or lips							
13131	10	5	5	45	15	25th	3.73
13132	15	5	5	50	15	25th	4.78
13133	0	0	0	30	0	Maintain/25th	2.19
13151	10	5	8	45	15	Crosswalk	4.34
13152	20	5	8	50	20	Crosswalk	5.34
13153	0	0	0	45	0	Maintain	2.38

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm (For 1.0 cm or less, see simple or intermediate repairs)	010	3.00
13101	2.6 cm to 7.5 cm	010	3.50
+13102	each additional 5 cm or less (List separately in addition to code for primary procedure)	ZZZ	1.24 (No Change)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm (For 1.0 cm or less, see simple or intermediate repairs)	010	3.23
13121	2.6 cm to 7.5 cm	010	4.00
13122	each additional 5 cm or less (List separately in addition to code for primary procedure) (Use 13122 in conjunction with 13121)	ZZZ	1.44 (No Change)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm (For 1.0 cm or less, see simple or intermediate repairs)	010	3.73
13132	2.6 cm to 7.5 cm	010	4.78

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+13133	each additional 5 cm or less (List separately in addition to code for primary procedure) (Use 13133 in conjunction with 13132)	ZZZ	2.19 (No Change)
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less (See also 40650-40654, 67961-67975)	010	Refer to CPT For Deletion of Code
13151	1.1 cm to 2.5 cm	010	4.34
13152	2.6 cm to 7.5 cm	010	5.34
+13153	each additional 5 cm or less (List separately in addition to code for primary procedure)	ZZZ	2.38 (No Change)

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April 2, 2012

Barbara Levy, M.D.
Chair, Relative Value Scale Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

RE: Tab 38: Complex Wound Repair; Deletion of CPT 13150

Dear Dr. Levy:

Please accept this letter on behalf of the American Academy of Dermatology (AAD), the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS), and the American Society of Plastic Surgery (ASPS). Together, our societies surveyed the family of complex wound repair CPT codes; 13100 – 13153, representing Tab 38 for the upcoming April Relative Update Committee (RUC) meeting.

We are writing to outline our request, presented to the Research Sub-committee during the February 27th call, to delete CPT 13150 *Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less.* Our rationale for this request is based upon our belief that the 1.0 cm or less size of this repair makes it a medically unlikely complex repair due to the small size of the repair. As stated on the call, our societies intend to submit a CPT proposal requesting deletion of this code by the July 2012 deadline for consideration at the October 2012 CPT meeting. Given that the Research Sub-committee was receptive to this proposal, we respectfully request that the RUC panel also approve our request for deletion of CPT 13150.

Thank you in advance for your consideration. We urge you to contact us with any questions or concerns regarding this proposal. You may reach the relevant Society staff at: Norma Border, AAD, at nborder@aad.org or 847-240-1814; Melanie Dolak, ASPS, at mdolak@plasticsurgery.org or 847-228-3317; or Jenna Minton, AAO-HNS, at jminton@entnet.org or 703.535.3725.

Sincerely,

Brett Coldiron, MD
AAD RUC Advisor

Wayne Koch, MD
AAO-HNS RUC Advisor

Martha Matthews, MD
ASPS RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13100 Tracking Number

Original Specialty Recommended RVU: 3.17
Presented Recommended RVU: 3.17
RUC Recommended RVU: 3.00

Global Period: 010

CPT Descriptor: Repair, complex, trunk; 1.1 cm to 2.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the back. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 2.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Further anesthesia is provided as indicated. The repair is incised to or through fascia and wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Mark Kaufman, MD				
Specialty(s):	AAD, ASPS				
CPT Code:	13100				
Sample Size:	800	**Resp N:**	101	**Response:** 12.6 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**18.00**	50.00	1021.00
Survey RVW:	0.40	3.00	**3.25**	3.53	5.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	10.00	25.00	**32.00**	45.00	54.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13100	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**17.00**	**-7.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**32.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12031	010	2.00	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11444	010	3.19	**RUC Time**	4,117

CPT Descriptor 1 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 26.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 13100**	**Key Reference CPT Code:** 12031	**Source of Time** RUC Time
Median Pre-Service Time	20.00	13.00	
Median Intra-Service Time	32.00	20.00	
Median Immediate Post-service Time	10.00	7.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**78.00**	***56.00***	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	2.96
Urgency of medical decision making	3.88	3.03
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.51	3.22
Physical effort required	4.22	3.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.96	3.04
Outcome depends on the skill and judgment of physician	4.29	3.37
Estimated risk of malpractice suit with poor outcome	3.40	2.85

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	2.81
Intra-Service intensity/complexity	4.22	3.18
Post-Service intensity/complexity	3.59	2.815

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) conducted a random survey of these codes. Using the member database we identified surgical subspecialty members who would likely have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-op	Total	RVU

MPC	11444	20	40	10	16	86	3.19
SVY	13100	20	32	10	16	78	3.17
K-REF	12031	13	20	7	16	56	2.00

Based on these comparisons, the CP recommends 3.17 work RVUs, the current value for 13100.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13100

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15525
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times Medicare utilization estimate

Specialty Dermatology Frequency 8862 Percentage 57.08 %

Specialty Plastic Surgery Frequency 3153 Percentage 20.30 %

Specialty Gen Surg, Fam Pract, Other Frequency 3510 Percentage 22.60 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,175 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 2954 Percentage 57.08 %

Specialty Plastic Surgery Frequency 1051 Percentage 20.30 %

Specialty Gen Surg, Fam Pract, Other Frequency 1170 Percentage 22.60 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13100

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13101 Tracking Number

Original Specialty Recommended RVU: 3.96
Presented Recommended RVU: 3.96
RUC Recommended RVU: 3.50

Global Period: 010

CPT Descriptor: Repair, complex, trunk; 2.6 cm to 7.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the back. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 6.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 99%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Further anesthesia is provided as indicated. The repair is incised to or through fascia and wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Brett Coldrion, MD; Glenn Goldman, MD; Melissa Crosby, MD(ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13101				
Sample Size: 101	**Resp N:** 95	**Response:** 94.0 %			
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**30.00**	81.00	900.00
Survey RVW:	2.10	3.50	**4.00**	4.50	12.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	15.00	30.00	**45.00**	59.00	120.00

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13101	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**17.00**	**-12.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**11.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12032	010	2.52	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11644	010	4.34	**RUC Time**	16,269

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 37.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 13101**	**Key Reference CPT Code:** 12032	**Source of Time RUC Time**
Median Pre-Service Time	15.00	14.00	
Median Intra-Service Time	45.00	30.00	
Median Immediate Post-service Time	11.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**87.00**	**68.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.89	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.00
Urgency of medical decision making	3.97	3.03
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.46	3.31
Physical effort required	4.26	3.15
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.09	3.06
Outcome depends on the skill and judgment of physician	4.20	3.26
Estimated risk of malpractice suit with poor outcome	3.71	2.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	2.77
Intra-Service intensity/complexity	4.34	3.23
Post-Service intensity/complexity	3.69	2.79

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified those surgical subspecialty

members who would likely have performed this procedure within the last twelve months. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-op	Total	RVU
MPC	11644	30	45	10	23	108	4.34
SVY	13101	15	45	11	16	87	3.96
K-REF	12032	14	30	8	16	68	2.52

Based on these comparisons, the CP recommends 3.96 work RVUs, the current value for 13101.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13101

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 178695
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times Medicare utilization

Specialty Dermatology Frequency 131628 Percentage 73.66 %

Specialty Plastic Surgery Frequency 24393 Percentage 13.65 %

Specialty Gen Surg, etc Frequency 22674 Percentage 12.68 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 59,565 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 43876 Percentage 73.66 %

Specialty Plastic Surgery Frequency 8131 Percentage 13.65 %

Specialty Gen Surg, etc Frequency 7558 Percentage 12.68 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13101

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13102 Tracking Number Original Specialty Recommended RVU: **1.24**
Presented Recommended RVU: **1.24**
Global Period: ZZZ RUC Recommended RVU: **1.24**

CPT Descriptor: Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the back. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 10.0 cm. Please note that this is an add-on code. The first 7.5 cm repaired is reported separately with code 13101. When completing this survey, only consider the additional work for the additional 2.5 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A - pre-service work included in global of primary procedure.

Description of Intra-Service Work: Intra-service work includes ongoing complex repair of wound length after the first 7.5 cm. This will involve additonal injection of local anesthetic, additional sharp incision, additional wide undermining, additional hemostasis by electrocautery and ligature, and additional multilayered suturing.

Description of Post-Service Work: N/A - Add on code Comment: In general no post time is applied to add on codes. However, in the extent of extensive wounds and/or lacerations requiring lengthy suture lines and/or mutliple suture lines additional provider time will be required to counsel the patient, review wound care, and see the patient durning the postoperative global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldrion, MD; Melissa Crosby, MD(ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13102				
Sample Size:	1050	**Resp N:**	128	**Response:** 12.1 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	**15.00**	25.00	100.00
Survey RVW:	0.50	1.50	**1.65**	2.00	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	20.00	**30.00**	36.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13102	**Recommended Physician Work RVU: 1.24**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93563	ZZZ	1.11	RUC Time

CPT Descriptor Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 29.6 **%**

TIME ESTIMATES (Median)	CPT Code: 13102	Key Reference CPT Code: 14302	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	3.50
Urgency of medical decision making	3.42	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.74	4.34
Physical effort required	3.58	4.16
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.47	4.03
Outcome depends on the skill and judgment of physician	3.87	4.39
Estimated risk of malpractice suit with poor outcome	3.45	3.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.97	3.58
Intra-Service intensity/complexity	3.63	4.11
Post-Service intensity/complexity	2.79	3.42

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified those surgical subspecialty members

who would likely have performed this procedure within the last twelve months. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-op	Total	RVU
K-Ref	14302	0	40	0	0	40	3.73
SVY	13102	0	30	0	0	30	1.24
Ref	93563	0	25	0	0	25	1.11

Based on these comparisons, the CP recommends 1.24 work RVUs, the current value for 13102, a value significantly below the 25th percentile.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 13100 &13101 - Base codes

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FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13102

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 49419
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times Medicare Utilization

Specialty Dermatology Frequency 17658 Percentage 35.73 %

Specialty Plastic Surgery Frequency 20169 Percentage 40.81 %

Specialty Gen Surgery, etc Frequency 11592 Percentage 23.45 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 16,473 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 5886 Percentage 35.73 %

Specialty Plastic Surgery Frequency 6723 Percentage 40.81 %

Specialty Gen Surgery, etc Frequency 3864 Percentage 23.45 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13102

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13120 Tracking Number Original Specialty Recommended RVU: 3.35
Presented Recommended RVU: 3.35
Global Period: 010 RUC Recommended RVU: 3.23

CPT Descriptor: Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the scalp. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 2.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Further anesthesia is provided as indicated. The repair is incised to or through fascia and wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldiron; MD				
Specialty(s):	AAD, ASPS				
CPT Code:	13120				
Sample Size:	800	**Resp N:**	82	**Response:** 10.2 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**25.00**	50.00	678.00
Survey RVW:	2.05	3.23	**3.50**	3.90	5.50
Pre-Service Evaluation Time:			**14.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.00**		
Intra-Service Time:	15.00	20.00	**35.00**	49.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13120	**Recommended Physician Work RVU: 3.23**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**17.00**	**-3.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12031	010	2.00	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11643	010	3.42	**RUC Time**	47,757

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 26.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 13120**	**Key Reference CPT Code:** 12031	**Source of Time** RUC Time
Median Pre-Service Time	24.00	13.00	
Median Intra-Service Time	35.00	20.00	
Median Immediate Post-service Time	10.00	7.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**85.00**	**56.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.68	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	2.90
Urgency of medical decision making	3.63	2.90
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.36	3.00
Physical effort required	4.13	2.95
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.09	2.90
Outcome depends on the skill and judgment of physician	4.36	3.27
Estimated risk of malpractice suit with poor outcome	3.68	2.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.68	2.77
Intra-Service intensity/complexity	4.13	3.00
Post-Service intensity/complexity	3.36	2.63

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) conducted a random survey of these codes. Using the member database we identified surgical subspecialty members who would likely have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of surgeons.

The AAD Consensus Panel (CP) reviewed the survey data from 101 dermatologists and determined that the pre-service time package that should be selected is package 6. Modifications to the pre-service time package are made to better

reflect pre-service time activities. Further modifications were made to the positioning time as specialized patient positioning is required for the success of the procedure. Both of these modifications are supported by the survey data. Therefore, the CP recommends pre-service time of 14 minutes evaluation, 5 minutes positioning and 5 minutes of scrub dress and wait.

The CP reviewed the surveyed code in comparison to the key reference code 12031 (Work RVU=2.00) and noted that the surveyed code has significantly more intra-service time associated with it as compared to the reference code, 35 minutes and 20 minutes. Further, the surveyed code requires significantly more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code.

In addition, the CP compared the surveyed code to MPC code 11643 (work RVU=3.42). The CP noted that the 11643 has 93 minutes of total service time and the surveyed code has 86 minutes of total service time.

		Pre	Intra	Post	Post-Op	Total	RVU
MPC	11643	30	30	10	23	93	3.42
SVY	13120	25	35	10	16	86	3.35
K-REF	12031	13	20	7	16	56	2.00

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13120

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 23553
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times Medicare Utilization

Specialty Dermatology Frequency 15375 Percentage 65.27 %

Specialty Plastic Surgery Frequency 4080 Percentage 17.32 %

Specialty Gen Surg, Fam Prac, etc Frequency 4098 Percentage 17.39 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,851 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 5125 Percentage 65.27 %

Specialty Plastic Surgery Frequency 1360 Percentage 17.32 %

Specialty Gen Surg, Fam Prac, Etc Frequency 1366 Percentage 17.39 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13120

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13121 Tracking Number Original Specialty Recommended RVU: **4.42**
Presented Recommended RVU: **4.42**
Global Period: 010 RUC Recommended RVU: **4.00**

CPT Descriptor: Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the scalp. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 6.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Further anesthesia is provided as indicated. The repair is incised to or through fascia and wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldrion, MD; Melissa Crosby, MD(ASPS) Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13121				
Sample Size:	1050	**Resp N:**	94	**Response:** 8.9 %	
Description of Sample:	Random				

	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	19.00	**45.00**	100.00	650.00
Survey RVW:	0.50	4.00	**4.50**	5.20	6.50
Pre-Service Evaluation Time:			**16.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**8.00**		
Intra-Service Time:	20.00	35.00	**45.00**	69.00	85.00

Immediate Post Service-Time:	**23.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**32.00**	99211x **0.00** 12x **2.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13121	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**16.00**	**17.00**	**-1.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11606	010	5.02	**RUC Time**

CPT Descriptor Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11644	010	4.34	**RUC Time**	16,269

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 28.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 13121**	**Key Reference CPT Code:** 11606	**Source of Time RUC Time**
Median Pre-Service Time	26.00	30.00	
Median Intra-Service Time	45.00	90.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**97.00**	**153.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	3.44
Urgency of medical decision making	3.63	3.48
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.14	3.88
Physical effort required	4.00	3.63
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.74
Outcome depends on the skill and judgment of physician	4.14	3.81
Estimated risk of malpractice suit with poor outcome	3.55	3.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.37	3.48
Intra-Service intensity/complexity	4.11	3.81
Post-Service intensity/complexity	3.63	3.48

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified those surgical subspecialty members who would likely have performed this procedure within the last twelve months. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU

K-REF	11606	30	90	10	23	153	5.02
SVY	13121	29	45	23	16	113	4.42
MPC	11644	30	45	10	23	108	4.34

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13121

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 291591
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times Medicare utilization

Specialty Dermatology Frequency 226830 Percentage 77.79 %

Specialty Plastic Surgery Frequency 29889 Percentage 10.25 %

Specialty Gen Surg, Fam Pract, etc Frequency 34872 Percentage 11.95 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 97,197 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 75610 Percentage 77.79 %

Specialty Plastic Surgery Frequency 9963 Percentage 10.25 %

Specialty Gen Surg, Fam Pract, etc Frequency 11624 Percentage 11.95 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13121

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13122 Tracking Number Original Specialty Recommended RVU: **1.44**
Presented Recommended RVU: **1.44**
Global Period: ZZZ RUC Recommended RVU: **1.44**

CPT Descriptor: Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the scalp. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 10.0 cm. Please note that this is an add-on code. The first 7.5 cm repaired is reported separately with code 13121. When completing this survey, only consider the additional work for the additional 2.5 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A - pre-service work included in global of primary procedure.

Description of Intra-Service Work: Intra-service work includes ongoing complex repair of wound length after the first 7.5 cm. This will involve additonal injection of local anesthetic, additional sharp incision, additional wide undermining, additional hemostasis by electrocautery and ligature, and additional multilayered suturing.

Description of Post-Service Work: N/A - Add on code Comment: In general no post time is applied to add on codes. However, in the extent of extensive wounds and/or lacerations requiring lengthy suture lines and/or mutliple suture lines additional provider time will be required to counsel the patient, review wound care, and see the patient durning the postoperative global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldiron, MD; Melissa Crosby, MD(ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13122				
Sample Size:	1050	**Resp N:**	96	**Response:** 9.1 %	
Description of Sample:	Random				

	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	5.00	**12.00**	24.00	100.00
Survey RVW:	0.50	1.50	**1.75**	2.00	4.00
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	20.00	**30.00**	45.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13122	**Recommended Physician Work RVU: 1.44**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**17.00**	**-17.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
			RUC Time	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93563	ZZZ	1.11	RUC Time

CPT Descriptor Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 36.4 **%**

TIME ESTIMATES (Median)	CPT Code: 13122	Key Reference CPT Code: 14302	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.30	3.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	3.44
Urgency of medical decision making	3.39	3.97
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.85	4.34
Physical effort required	3.58	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.55	4.00
Outcome depends on the skill and judgment of physician	3.85	4.28
Estimated risk of malpractice suit with poor outcome	3.39	3.75

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.09	3.56
Intra-Service intensity/complexity	3.76	4.13
Post-Service intensity/complexity	3.06	4.13

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified those surgical subspecialty members

who would likely have performed this procedure within the last twelve months. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU
K-REF	14302		40			40	3.73
SVY	13122		30			30	1.44
Ref	93563		25			25	1.11

Based on these comparisons, the CP recommends 1.44 work RVUs the current work RVU, which is slightly below the 25th percentile for 13122.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 13120 & 13121 Base codes

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FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13122

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 49557
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times the Medicare utilization

Specialty Dermatology Frequency 21147 Percentage 42.67 %

Specialty Plastic Surgery Frequency 11682 Percentage 23.57 %

Specialty Orthopaedic Surg, Gen Surg, etc Frequency 16728 Percentage 33.75 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 16,519 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 7049 Percentage 42.67 %

Specialty Plastic Surgery Frequency 3894 Percentage 23.57 %

Specialty Orthopaedic Surg, Gen Surg, etc Frequency 5576 Percentage 33.75 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13122

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13131 Tracking Number Original Specialty Recommended RVU: 3.83
Presented Recommended RVU: 3.83
Global Period: 010 RUC Recommended RVU: 3.73

CPT Descriptor: Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the forehead. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 2.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Closure is carefully planned along skin tension lines and in a manner to avoid tension on / alteration of free margins. Further anesthesia is provided as indicated. The repair is incised to or through fascia and the wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldiron, MD				
Specialty(s):	AAD, ASPS				
CPT Code:	13131				
Sample Size:	800	**Resp N:**	87	**Response:** 10.8 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	20.00	**42.00**	77.00	800.00
Survey RVW:	2.00	3.73	**4.00**	4.30	5.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	20.00	32.00	**45.00**	50.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13131	**Recommended Physician Work RVU: 3.73**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**17.00**	**-7.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12054	010	3.50	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38500	010	3.79	**RUC Time**	12,131

CPT Descriptor 1 Biopsy or excision of lymph node(s); open, superficial

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 13131**	**Key Reference CPT Code:** 12054	**Source of Time** RUC Time
Median Pre-Service Time	20.00	20.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**96.00**	**96.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.95	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.00
Urgency of medical decision making	4.00	3.42
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.57	3.57
Physical effort required	4.14	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.14	3.23
Outcome depends on the skill and judgment of physician	4.57	3.61
Estimated risk of malpractice suit with poor outcome	4.23	3.19

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.66	3.00
Intra-Service intensity/complexity	4.28	3.57
Post-Service intensity/complexity	3.85	3.19

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) conducted a random survey of these codes. Using the member database we identified surgical subspecialty members who would likely have performed this procedure within the last twelve months. AAD distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU
MPC	11644	30	45	10	23	108	4.34
SVY	13131	20	45	15	16	96	3.73
K-REF	12054	20	50	10	16	96	3.50

Based on these comparisons, the CP recommends 3.83 work RVUs, the current work RVU for 13131.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13131

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 98631
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times Medicare utilization

Specialty Dermatology Frequency 71175 Percentage 72.16 %

Specialty Plastic Surgery Frequency 14382 Percentage 14.58 %

Specialty ENT, Fam Pract Frequency 13074 Percentage 13.25 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 32,877 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology Frequency 23725 Percentage 72.16 %

Specialty Plastic Surgery Frequency 4794 Percentage 14.58 %

Specialty ENT, Fam Pract Frequency 4358 Percentage 13.25 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13131

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13132 Tracking Number Original Specialty Recommended RVU: 6.00
Presented Recommended RVU: 6.00
Global Period: 010 RUC Recommended RVU: 4.78

CPT Descriptor: Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the forehead. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 6.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 8% , In the ASC 0%, In the office 92%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 8% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Closure is carefully planned along skin tension lines and in a manner to avoid tension on / alteration of free margins. Further anesthesia is provided as indicated. The repair is incised to or through fascia and the wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldiron, MD; Wayne Koch, MD (AAO-HNS); Melissa Crosby, MD (ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS, AAO-HNS				
CPT Code:	13132				
Sample Size:	2177	**Resp N:**	115	**Response:** 5.2 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	15.00	**50.00**	150.00	750.00
Survey RVW:	1.50	4.78	**6.00**	6.64	10.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**7.00**		
Intra-Service Time:	5.00	33.00	**50.00**	63.00	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13132	**Recommended Physician Work RVU: 4.78**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**17.00**	**-2.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12054	010	3.50	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38510	010	6.74	**RUC Time**	9,047

CPT Descriptor 1 Biopsy or excision of lymph node(s); open, deep cervical node(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 27.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 13132**	**Key Reference CPT Code:** 12054	**Source of Time RUC Time**
Median Pre-Service Time	25.00	20.00	
Median Intra-Service Time	50.00	50.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**106.00**	**96.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.97	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.39	2.94
Urgency of medical decision making	3.76	3.06
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.45	3.41
Physical effort required	4.12	3.34
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.12	3.28
Outcome depends on the skill and judgment of physician	4.42	3.56
Estimated risk of malpractice suit with poor outcome	4.18	3.28

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.64	2.91
Intra-Service intensity/complexity	4.36	3.59
Post-Service intensity/complexity	3.52	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD), the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified surgical subspecialty members who would likely have performed this procedure within the last twelve months. AAO-HNS queried this subset of their membership to determine if they had performed the procedure and were willing to participate in the survey.

AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU
MPC	38510	45	45	20	42	152	6.74
SVY	13132	25	50	15	16	108	4.78
K-REF	12054	20	50	10	16	96	3.50

Based on these comparisons, the CP recommends 6.00 work RVUs, the median which is significantly less than the current work RVU for 13132.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 17311 000 6.20 pre- 20 intra- 110 post- 8 Both codes are subject to the multiple procedure reduction.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13132

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty Otolaryngology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 564456
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Three times the Medicare Utilization

Specialty Dermatology Frequency 471267 Percentage 83.49 %

Specialty Plastic Surgery Frequency 48150 Percentage 8.53 %

Specialty Otolaryngology Frequency 17950 Percentage 3.18 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 188,152
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Dermatology	Frequency 157089	Percentage 83.49 %
Specialty Plastic Surgery	Frequency 16050	Percentage 8.53 %
Specialty Otolaryngology	Frequency 5983	Percentage 3.17 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13132

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13133 Tracking Number Original Specialty Recommended RVU: **2.19**
Presented Recommended RVU: **2.19**
Global Period: ZZZ RUC Recommended RVU: **2.19**

CPT Descriptor: Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the forehead. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 10.0 cm. Please note that this is an add-on code. The first 7.5 cm repaired is reported separately with code 13132. When completing this survey, only consider the additional work for the additional 2.5 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A - pre-service work included in global of primary procedure.

Description of Intra-Service Work: Intra-service work includes ongoing complex repair of wound length after the first 7.5 cm. This will involve additonal injection of local anesthetic, additional sharp incision, additional wide undermining, additional hemostasis by electrocautery and ligature, and additional multilayered suturing.

Description of Post-Service Work: N/A - Add on code Comment: In general no post time is applied to add on codes. However, in the extent of extensive wounds and/or lacerations requiring lengthy suture lines and/or mutliple suture lines additional provider time will be required to counsel the patient, review wound care, and see the patient durning the postoperative global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldiron, MD; Melissa Crosby, MD (ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13133				
Sample Size:	1050	**Resp N:**	93	**Response:** 8.8 %	
Description of Sample:	Random				

	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	4.00	**10.00**	26.00	100.00
Survey RVW:	0.50	2.19	**2.29**	2.50	5.01
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	20.00	**35.00**	50.00	90.00

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	13133	**Recommended Physician Work RVU: 2.19**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93563	ZZZ	1.11	RUC Time	0

CPT Descriptor 1 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39 **% of respondents:** 41.9 **%**

TIME ESTIMATES (Median)	CPT Code: 13133	Key Reference CPT Code: 14302	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	35.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	3.34
Urgency of medical decision making	3.68	3.92
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.08	4.26
Physical effort required	3.82	3.92
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.84	4.00
Outcome depends on the skill and judgment of physician	4.18	4.24
Estimated risk of malpractice suit with poor outcome	3.68	3.84

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.32	3.63
Intra-Service intensity/complexity	3.79	4.05
Post-Service intensity/complexity	3.21	3.53

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified those surgical subspecialty

members who would likely have performed this procedure within the last twelve months. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU
K-REF	14302		40			40	3.73
SVY	13133		35			35	2.19
Ref	93563		25			25	1.11

Based on these comparisons, the CP recommends 2.19 work RVUs, the 25th percentile which also is the current work RVU for 13133.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 13131 & 13132

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13133

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Sometimes

Specialty Gen Surg, Otolaryngology etc How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 33066
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 3X Medicare Utilization

Specialty Dermatology Frequency 18617 Percentage 56.30 %

Specialty Plastics Frequency 8168 Percentage 24.70 %

Specialty Gen Surg, Otolaryngology etc Frequency 6282 Percentage 18.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,022 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 6206 Percentage 56.30 %

Specialty Plastic Surgery Frequency 2723 Percentage 24.70 %

Specialty Gen Surg, Otolaryngology etc Frequency 431 Percentage 3.91 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13133

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13151 Tracking Number

Original Specialty Recommended RVU: 4.49
Presented Recommended RVU: 4.49
RUC Recommended RVU: 4.34

Global Period: 010

CPT Descriptor: Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the nose. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 2.0 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 30% , In the ASC 3%, In the office 67%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 23% , Overnight stay-less than 24 hours 2% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 10%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Closure is carefully planned along skin tension lines and in a manner to avoid tension on / alteration of free margins. Further anesthesia is provided as indicated. The repair is incised to or through fascia and the wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldrion, MD, Wayne Koch, MD				
Specialty(s):	AAD, AAO-HNS				
CPT Code:	13151				
Sample Size:	1927	**Resp N:**	144	**Response:** 7.4 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**24.00**	65.00	550.00
Survey RVW:	1.00	3.50	**4.50**	5.66	12.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13151	**Recommended Physician Work RVU: 4.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**17.00**	**-7.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**8.00**	**5.00**	**3.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

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New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

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KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12054	010	3.50	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

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KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11626	010	4.61	**RUC Time**	8,409

CPT Descriptor 1 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 34 **% of respondents:** 23.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 13151**	**Key Reference CPT Code:** 12054	**Source of Time** RUC Time
Median Pre-Service Time	23.00	20.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**99.00**	**96.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.87	3.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	2.87
Urgency of medical decision making	3.87	3.37
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.87	3.50
Physical effort required	3.25	3.12
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.62	3.50
Outcome depends on the skill and judgment of physician	4.12	3.62
Estimated risk of malpractice suit with poor outcome	3.50	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.37	3.62
Intra-Service intensity/complexity	3.75	3.87
Post-Service intensity/complexity	3.25	3.50

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) have each conducted a random survey of these codes. Using their respective member databases, they identified surgical subspecialty members who would likely have performed this procedure within the last twelve months.

In addition, AAO-HNS queried this subset of their membership to determine if they had performed the procedure and were willing to participate in the survey. AAD distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU
MPC	11626	30	60	10	23	123	4.61
SVY	13151	23	45	15	16	101	4.34
K-Ref	12054	20	50	10	16	96	3.50

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Repair of wound or excision

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. AAD - 17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13151

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Otolaryngology How often? Sometimes

Specialty Plastic Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 90921
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate done 3X more than Medicare population

Specialty Dermatology Frequency 66500 Percentage 73.14 %

Specialty Plastics Frequency 14712 Percentage 16.18 %

Specialty Otolaryngology Frequency 6209 Percentage 6.82 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,307 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data

Specialty Dermatology Frequency 22167 Percentage 73.14 %

Specialty Plastics Frequency 4904 Percentage 16.18 %

Specialty Otolaryngology Frequency 2069 Percentage 6.82 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13151

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13152 Tracking Number Original Specialty Recommended RVU: 6.37
Presented Recommended RVU: 6.37
Global Period: 010 RUC Recommended RVU: 5.34

CPT Descriptor: Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the nose. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 3.5 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 1% , In the ASC 3%, In the office 96%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: The history and exam are reviewed. The procedure is explained to the patient / family. The risks and potential complications are reviewed. Communication with the referring physician is undertaken as indicated. Written consent is obtained. The patient is transferred to the operative table and is positioned for the procedure. The site is identified and a time out is performed. Photographs are obtained as indicated. The area is prepped and draped in the usual sterile fashion. Local anesthetic is administered. The provider scrubs and dons gown, mask, and sterile gloves. The instruments are examined. Suture is obtained and placed on the surgical tray.

Description of Intra-Service Work: The wound is examined with sterile gloves and appropriate closure direction is determined. The closure is drawn onto the skin with a sterile marking pen, thus delineating a fusiform closure. Closure is carefully planned along skin tension lines and in a manner to avoid tension on / alteration of free margins. Further anesthesia is provided as indicated. The repair is incised to or through fascia and the wound edges are freshened as needed. The wound is extensively undermined. Hemostasis is obtained with spot electrocautery and ligature as indicated. The wound is closed in a multilayered fashion including retention sutures and / or stents as indicated. Final hemostasis is verified. The closure is assessed for cosmesis.

Description of Post-Service Work: All sterile prep is removed with sterile saline or peroxide. The wound is dressed in the usual sterile fashion with petrolatum, non-stick gauze pad, absorbant gauze, and cloth tape. Postoperative wound care and activity restrictions are discussed with the patient and provided in writing. Orders for postoperative antibiotic and pain medication are written as appropriate. The operative report is either dictated or completed in the electronic medical record. Photos are obtained as indicated. The patient is examined within the first week for a wound check and again as needed throughout the 10-day global period. Sutures are generally removed at 7 to 10 days. Communication is provided verbally and/or in writing/electronically to the primary care or referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldrion, MD; Wayne Koch, MD (AAO-HNS); Melissa Crosby, MD(ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13152				
Sample Size:	2177	**Resp N:**	107	**Response:** 9.3 %	
Description of Sample:	Random				

	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	12.00	**40.00**	100.00	600.00
Survey RVW:	3.35	4.90	**6.39**	7.00	40.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**8.00**		
Intra-Service Time:	10.00	35.00	**50.00**	84.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	13152	**Recommended Physician Work RVU: 5.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**17.00**	**3.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**8.00**	**5.00**	**3.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
12054	010	3.50	**RUC Time**

CPT Descriptor Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38510	010	6.74	**RUC Time**	9,047

CPT Descriptor 1 Biopsy or excision of lymph node(s); open, deep cervical node(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 35.5 **%**

TIME ESTIMATES (Median)	CPT Code: 13152	Key Reference CPT Code: 12054	Source of Time RUC Time
Median Pre-Service Time	33.00	20.00	
Median Intra-Service Time	50.00	50.00	
Median Immediate Post-service Time	20.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**119.00**	**96.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	2.63
Urgency of medical decision making	3.63	2.91
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.59	3.44
Physical effort required	4.09	3.19
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.22	3.09
Outcome depends on the skill and judgment of physician	4.56	3.38
Estimated risk of malpractice suit with poor outcome	4.41	3.06

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.72	2.84
Intra-Service intensity/complexity	4.44	3.41
Post-Service intensity/complexity	3.59	2.84

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD), the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified surgical subspecialty members who would likely have performed this procedure within the last twelve months. AAO-HNS queried this subset of their membership to determine if they had performed the procedure and were willing to participate in the survey. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

		Pre	Intra	Post	Post-Op	Total	RVU
MPC	38510	45	45	20	42	152	6.74
SVY	13152	33	50	20	16	119	5.34
Ref	12054	20	50	10	16	96	3.50

Based on this comparison, the CP recommends 6.37 work RVUs, the current value for 13152.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Repair of wound or excision

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. AAD - 17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks. NOTE: Both subject to multiple procedure reduction

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13152

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Commonly

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 130251
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate done 3X more than Medicare population

Specialty Dermatology Frequency 99147 Percentage 76.11 %

Specialty Otolaryngology Frequency 5861 Percentage 4.49 %

Specialty Plastic Surgery Frequency 17910 Percentage 13.75 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 43,417 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology Frequency 32997 Percentage 76.00 %

Specialty Otolaryngology Frequency 1954 Percentage 4.50 %

Specialty Plastic Surgery Frequency 5970 Percentage 13.75 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13152

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:13153 Tracking Number Original Specialty Recommended RVU: 2.38
Presented Recommended RVU: 2.38
Global Period: ZZZ RUC Recommended RVU: 2.38

CPT Descriptor: Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less
(List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with a skin and soft tissue defect on the nose and cheek. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 9.0 cm. Please note that this is an add-on code. The first 7.5 cm repaired is reported separately with code 13152. When completing this survey, only consider the additional work for the additional 1.5 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A - pre-service work included in global of primary procedure.

Description of Intra-Service Work: Intra-service work includes assessment and complex repair of wound length after the first 2.5 cm. This may involve: additional draping; additional injection of local anesthetic; additional removal of wound debris; additional irrigation with sterile saline; additional suturing of ligated vessels; additional electrocauterization for hemostasis; additional repair of muscle(s) deep fascial layer(s); additional suturing of skin; and additional dresssing application.

Description of Post-Service Work: N/A - Add on code Comment: In general no post time is applied to add on codes. However, in the extent of extensive wounds and/or lacerations requiring lengthy suture lines and/or mutliple suture lines additional provider time will be required to counsel the patient, review wound care, and see the patient durning the postoperative global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Glenn Goldman, MD; Brett Coldiron, MD; Melissa Crosby, MD(ASPS); Mark Villa, MD(ASPS)				
Specialty(s):	AAD, ASPS				
CPT Code:	13153				
Sample Size:	1050	**Resp N:**	92	**Response:** 8.7 %	
Description of Sample:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**8.00**	16.00	50.00
Survey RVW:	0.75	2.20	**2.40**	3.00	4.00
Pre-Service Evaluation Time:			**1.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	25.00	**45.00**	60.00	65.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	13153	**Recommended Physician Work RVU: 2.38**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22116	ZZZ	2.32	RUC Time	176

CPT Descriptor 1 Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 45 **% of respondents:** 48.9 **%**

TIME ESTIMATES (Median)	CPT Code: 13153	Key Reference CPT Code: 14302	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	45.00	40.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.49
Urgency of medical decision making	3.89	3.87
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.24	4.27
Physical effort required	4.02	3.98
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.11	4.09
Outcome depends on the skill and judgment of physician	4.22	4.20
Estimated risk of malpractice suit with poor outcome	3.91	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.52	3.60
Intra-Service intensity/complexity	4.14	4.27
Post-Service intensity/complexity	3.70	3.71

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Society of Plastic Surgeons have each conducted a random survey of these codes. Using their respective member databases, they identified those surgical subspecialty members

who would likely have performed this procedure within the last twelve months. AAD and ASPS distributed the survey(s) directly to the identified random sample of surgeons.

After the surveys were completed, our consensus panel realized that the vignette for CPT 13153 has an error. The vignette reads: "A patient presents with a skin and soft tissue defect on the nose and cheek. To achieve tension free closure, extensive undermining is performed and appropriate sutures are placed. The final wound length is 9.0 cm. Please note that this is an add-on code. The first 7.5 cm repaired is reported separately with code 13152. When completing this survey, only consider the additional work for the additional 1.5 cm."

Repair of the cheek is not included in the CPT 13153 descriptor. Thus, the vignette should have read "A patient presents with a skin and soft tissue defect on the nose..." Our consensus panel discussed this issue and felt that the survey results are still appropriate.

We also would like to recommend to the RUC that the vignette should be modified to specify nose only.

		Pre	Intra	Post	Post-Op	Total	RVU
K-Ref	14302		40			40	3.73
SVY	13153		45			45	2.38
Ref	22116		45			45	2.32

Based on these comparisons, the CP recommends 2.38 work RVUs, the current value for 13153.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 13152 & 13151

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 13153

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology How often? Sometimes

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate done 3X more than Medicare population

Specialty Dermatology Frequency 1044 Percentage 29.00 %

Specialty Otolaryngology Frequency 432 Percentage 12.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology Frequency 348 Percentage 29.00 %

Specialty Otolaryngology Frequency 144 Percentage 12.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 13153

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12031	Repair, intermediate,				2.00			56	7	1	5			20			7															1
CURRENT	13100	Repair, complex,				3.17			91	21					33			21															1
SVY	13100	Repair, complex, trunk		0.40	3.00	3.25	3.53	5.50	78	10	5	5	10	25	32	45	54	10															1
RUC REC	13100	Repair, complex, trunk		3.00					78	10	5	5			32			10															1

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12032	Repair, intermediate,				2.52			68	8	1	5			30			8															1
CURRENT	13101	Repair, complex,				3.96			111	21					53			21															1
SVY	13101	Repair, comple	116	2.10	3.50	4.00	4.50	12.50	87	5	5	5	15	30	45	59	120	11															1
RUC REC	13101	Repair, complex, trunk		3.50					87	5	5	5			45			11															1

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	14302	Adjacent tissue transfer				3.73			40						40																			
CURRENT	13102	Repair, complex,				1.24			25						25																			
SVY	13102	Repair, comple	90	0.50	1.50	1.65	2.00	10.00	30	0	0	0	2	20	30	36	45	0																
RUC REC	13102	Repair, complex, trunk		1.24					30						30																			

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

Source	CPT	DESC	Resp	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11
REF	12031	Repair, intermediate,				2.00			56	7	1	5			20			7														1	
CURRENT	13120	Repair, complex,				3.35			93	21					35			21														1	
SVY	13120	Repair, comple	101	2.05	3.23	3.50	3.90	5.50	86	14	5	6	15	20	35	49	60	10														1	
RUC REC	13120	Repair, complex, scalp		3.23					85	14	5	5			35			10														1	

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

Source	CPT	DESC	Resp	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11
REF	11606	Excision, malignant				5.02			153	20	5	5			90			10													1		
CURRENT	13121	Repair, complex,				4.42			117	10					60			15														2	
SVY	13121	Repair, comple	94	0.50	4.00	4.50	5.20	6.50	129	16	5	8	20	35	45	69	85	23														2	
RUC REC	13121	Repair, complex, scalp		4.00					97	16	5	5			45			10														1	

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

Source	CPT	DESC	Resp	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11
REF	14302	Adjacent tissue				3.73			40						40																		
CURRENT	13122	Repair, complex,				1.44			23						23																		
SVY	13122	Repair, comple	96	0.50	1.50	1.75	2.00	4.00	32	2	0	0	2	20	30	45	90	0															
RUC REC	13122	Repair, complex, scalp		1.44					30						30																		

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12054	Repair, intermediate,				3.50			96	12	3	5			50			10																1
CURRENT	13131	Repair, complex,				3.83			97	19					43			19																1
SVY	13131	Repair, comple	87	2.00	3.73	4.00	4.30	5.50	96	10	5	5	20	32	45	50	60	15																1
RUC REC	13131	Repair, complex, forel		3.73					96	10	5	5			45			15																1

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12054	Repair, intermediate,				3.50			96	12	3	5			50			10																1
CURRENT	13132	Repair, complex,				6.58			136	30					45			15																2
SVY	13132	Repair, comple	115	1.50	4.78	6.00	6.64	10.00	138	15	5	7	5	33	50	63	120	15																2
RUC REC	13132	Repair, complex, forel		4.78					106	15	5	5			50			15																1

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	14302	Adjacent tissue transfer				3.73			40						40																			
CURRENT	13133	Repair, complex,				2.19			30						30																			
SVY	13133	Repair, comple	93	0.50	2.19	2.29	2.50	5.01	39	0	0	0	2	20	35	50	90	4																
RUC REC	13133	Repair, complex, forel		2.19					30						30																			

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12054	Repair, intermediate,				3.50			96	12	3	5			50			10																1
CURRENT	13151	Repair, complex,				4.49			124	26					57			25																1
SVY	13151	Repair, comple	144	1.00	3.50	4.50	5.66	12.00	101	10	5	10	15	30	45	60	120	15																1
RUC REC	13151	Repair, complex, eyeli		4.34					99	10	5	8			45			15																1

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	12054	Repair, intermediate,				3.50			96	12	3	5			50			10																1
CURRENT	13152	Repair, complex,				6.37			141	26					73			26																1
SVY	13152	Repair, comple	107	3.35	4.90	6.39	7.00	40.00	119	20	5	8	10	35	50	84	120	20																1
RUC REC	13152	Repair, complex, eyeli		5.34					119	20	5	8			50			20																1

ISSUE: **CMS Request – CMS High Expenditure Procedure Codes**

TAB: 37

				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office				
Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11
REF	14302	Adjacent tissue				3.73			40						40																			
CURRENT	13153	Repair, complex,				2.38			45						45																			
SVY	13153	Repair, comple	92	0.75	2.20	2.40	3.00	4.00	48	1			5	25	45	60	65	2																
RUC REC	13153	Repair, complex, eyeli		2.38					45						45																			

CPT Code: 13100; 13101; 13102; 13120; 13121; 13122; 13131; 13132; 13133; 13150; 13151; 13152; 13153

Specialty Society('s): American Academy of Dermatology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

13100 Repair, complex, trunk; 1.1 cm to 2.5 cm

13101 Repair, complex, trunk; 2.6 cm to 7.5 cm

13102 Repair, complex, trunk; each additional 5 cm

13120 Repair, complex, scalp, arms, and/or legs; 1.1-2.5 cm

13121 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

13122 Repair, complex, scalp, arms, and/or legs; each additional 5 cm

13131 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm

13132 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

13133 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5cm

13150 Remove Code

13151 Repair, complex, eyelids, nose, ears and/or lips; 1.1-2.5 cm

13152 Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm - 7.5 cm

13153 Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm

Global Period: **010** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AAD RB/RVS committee has reviewed the RUC approved PE direct inputs for these codes as well as determined from industry data that there are no significant additions or changes to these inputs. The AAD Coding & Reimbursement Task Force as well as the RUC advisors for AAD, ASDS, ACMS and SID serve on the AAD RB/RVS committee.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

CPT Code: 13100; 13101; 13102; 13120; 13121; 13122; 13131; 13132; 13133; 13150; 13151; 13152; 13153

Specialty Society('s): American Academy of Dermatology

Please see PE Direct input spreadsheet.

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

Tab: 37AAD Revised 04/26/12

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	95.0	63.0	76.0	33.0	113.0	63.0	89.0	33.0	17.0	0.0	20.0	0.0	96.0	63.0	78.0	33.0	145.0	90.0	85.0	33.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	18.0	30.0	0.0	0.0	18.0	30.0	0.0	0.0	0.0	0.0	0.0	0.0	18.0	30.0	0.0	0.0	18.0	30.0	0.0	0.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	50.0	6.0	49.0	0.0	68.0	6.0	62.0	0.0	17.0	0.0	20.0	0.0	51.0	6.0	51.0	0.0	73.0	6.0	58.0	0.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	27.0	27.0	27.0	33.0	27.0	27.0	27.0	33.0	0.0	0.0	0.0	0.0	27.0	27.0	27.0	33.0	54.0	54.0	27.0	33.0
10	**PRE-SERVICE**																						
11	**Start: Following visit when decision for surgery or procedure made**																						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5			5	10							5	10			5	5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	5	5			3	3							3	3			3	10		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	3	3																5		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7			7	7							7	7			7	7		
16	Follow-up phone calls & prescriptions	L037D		3	10			3	10							3	10			3	3		
17	**End: When patient enters office/facility for surgery/procedure**																						
18	**SERVICE PERIOD**																						
19	**Start: When patient enters office/facility for surgery/procedure:**																						
20	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3		3		3						3		3		3		3	
21	Obtain vital signs	L037D	RN/LPN/MTA	3		3		3		3						3		3		3		3	
22	Provide pre-service education/obtain consent																			2			
23	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2		2						2		2		2		2	
24	Setup scope (non facility setting only)																						
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2		2						2		2		2		2	
26	Sedate/apply anesthesia	L037D	RN/LPN/MTA	2		2		2		2				0		2		2		2		2	
27	**Intra-service**																						
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	22		21		35		29		17		20		23		23		38		30	

Tab: 37AAD Revised 04/26/12

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
29	**Post-Service**																						
30	Monitor pt. following service/check tubes, monitors, drains																						
31	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**		**3**		3						3		3		3		3	
32	Clean Surgical Instrument Package	L037D		**10**		**10**		**15**		15						10		**10**		**15**		**10**	
33	Complete diagnostic forms, lab & X-ray requisitions																						
34	/prescriptions	L037D		**3**		**3**		**3**		3						3		**3**		**3**		**3**	
35	Other Clinical Activity - *specify:*	L037D			**6**				**6**								6				6		
36	**End: Patient leaves office**																						
37	**POST-SERVICE Period**																						
38	**Start: Patient leaves office/facility**																						
39	Conduct phone calls/call in prescriptions																						
40	***Office visits: List Number and Level of Office Visits***			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
41	Discharge day mgmt - same day (eg, 0.5 x 99238)		6	**n/a**		**n/a**	**1**	**n/a**		**n/a**	**1**			**n/a**				**n/a**	**1**			**n/a**	**1**
42	Discharge day mgmt - 99238		12	**n/a**		**n/a**		**n/a**		**n/a**				**n/a**				**n/a**				**n/a**	
43	Discharge day mgmt - 99239		15	**n/a**		**n/a**		**n/a**		**n/a**				**n/a**				**n/a**				**n/a**	
44	99211 16 minutes		16																				
45	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**					**1**	**1**	**1**	**1**	**2**	**2**	**1**	**1**
46	99213 36 minutes		36																				
47	99214 53 minutes		53																				
48	99215 63 minutes		63																				
49	**Total Office Visit Time**			**27**	**27**	**27**	**33**	**27**	**27**	**27**	**33**	**0**	**0**	**0**	**0**	**27**	**27**	**27**	**33**	**54**	**54**	**27**	**33**
50	Other Clinical Activity - *specify:*																						
51	**End: with last office visit before end of global period**																						

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
52	**MEDICAL SUPPLIES**	**CODE**	UNIT																				
53	pack, minimum multi-specialty visit	SA048	pack	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**					**2**	**1**	**2**	**1**	**3**	**2**	**2**	**1**
54	pack, post-op incision care (suture)	SA054	pack	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**					**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
55	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item			**1**				1				1				1				1	
56	scrub brush (impregnated)	SM023	item	**2**		**2**		**2**		2						2		**2**		**2**		**2**	
57	mask, surgical, with face shield	SB034	item	**2**		**1**		**2**		**1**	**1**					**2**		**1**	**1**	**2**		**1**	
58	gown, staff, impervious	SB027	item	**2**		**0**		**2**		0	0					2		**0**	**0**	**2**		**0**	
59	gown, surgical, sterile (for physician)	SB028	item			**1**				1	1							1	1			1	
60	gown, patient	SB026	item			**0**				0	0							0	0			0	
61	cap, surgical	SB001	item	**2**		**2**		**2**		2	2					2		**2**	**2**	**2**		**2**	
62	gloves, non-sterile, nitrile	SB023	pair			**0**				**0**	**0**							**0**	**0**			**0**	
63	gloves, sterile	SB024	pair	**2**		**2**		**2**		**2**	**2**					**2**		**2**	**2**	**2**		**2**	
64	skin marking pen, sterile (Skin Skribe)	SK075	item			**1**				1	1							1	1			1	
65	shoe covers, surgical	SB039	pair	**2**		**2**		**2**		**2**	**2**					**2**		**2**	**2**	**2**		**2**	
66	drape, sterile, for Mayo stand	SB012	item	**1**		**1**		**1**		1	1					1		1	1	1		1	
67	drape, sterile, u-shape	SB015	item			**1**				1								1				1	
68	drape, sterile, three-quarter sheet	SB014	item			**1**		**1**		1								1		1		1	
69	drape-cover, sterile, OR light handle	SB016	item	**1**		**1**		**2**		1						2		1		2		1	
70	povidone surgical scrub (Betadine)	SJ041	ml	**10**		**0**		**10**		0				0		10		0		10		0	
71	swab-pad, alcohol	SJ053	item	**2**		**2**		**2**		3				1		2		2		2		3	
72	applicator, cotton-tipped, sterile, 6in	SG081	item			**5**				10				5				5				10	
73	syringe 20 ml	SC053	ITEM	**1**				**1**								1				1			
74	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item			**2**				3				2		1		2				3	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
75	needle, 18-27g	SC029	item	**1**		**0**		**1**		0						1		0		1		0	
76	needle, 30g	SC031	item	**1**		**2**		**1**		3				2		1		2		1		3	
77	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml	**20cc**		**8cc**		**20cc**		12cc				8cc		20cc		8cc		20cc		12cc	
78	scalpel, safety, surgical, with blade (#10-20)	SF033	item	**1**		**1**		**1**		1				1		1		1		1		1	
79	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
80	drape-towel, sterile OR blue (2 pk uou)	SB020	item	**2**												2							
81	suture, nylon, 4-0 to 6-0, p, ps (1/2/1)	SF037	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
82	suture, vicryl, 3-0 to 6-0, p, ps (1/2/1)	SF040	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
83	cautery, patient ground pad w-cord	SF021	item	**1**		**1**		**1**		1						1		1		1		1	
84	tape, surgical paper 1in (Micropore)	SG079	inch	**12**		**12**		**24**		24		24		24		12		12		24		24	
85	steri-strip (6 strip uou)	SG074	item			**1**				2				1				1				2	
86	bacitracin oint (0.9gm uou)	SJ007	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
87	dressing, 3in x 4in (Telfa, Release)	SG035	item	**1**		**1**		**2**		2						1		1		2		2	
88	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			**1**				1								1				1	
89	cautery, monopolar, electrode tip	SF016	item	**1**		**0**		**1**		0						1		0		1		1	
90	pack, cleaning, surgical instruments	SA043	pack			**1**				1								1				1	
91	cautery, monopolar, pencil-handpiece	SF020	item			**1**				1								1				1	
92	Electrocautery Supply Pack	SF016	pack			**0**				0				0				0				0	
93	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			**3**				3								3				3	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
94	**EQUIPMENT**	**CODE**																					
95	light, surgical	EF014		**32**		**27**		**45**		27		30				86		27		129		27	
96	table, exam	EF023		**32**		**27**		**45**		27						86		27		129		27	
97	mayo stand	EF015				**39**				47								41				48	
98	electrosurgical generator, up to 120 watts	EQ114		**32**		**39**		**45**		47		30		30		86		41		129		48	
99	table, power	EF031		**32**		**32**		**45**		47		30				86		41		129		48	
100	instrument pack, basic ($500-$1499)	EQ137		**32**		**46**				54						86		48				55	
101	Smoke Evacuator(tubing, covering, etc.) with stand	EQ351				39				45								41				48	
102	Digital Camera Pkg - 6 megapixel medical grade	ED004		32				45								86				129			

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	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	GLOBAL PERIOD			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	15.0	0.0	20.0	0.0	102.0	63.0	85.0	33.0	153.0	108.0	93.0	33.0	20.0	0.0	23.0	0.0	99.0	63.0	71.0	3.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	18.0	30.0	0.0	0.0	18.0	30.0	0.0	0.0	0.0	0.0	0.0	0.0	18.0	30.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	15.0	0.0	20.0	0.0	57.0	6.0	58.0	0.0	63.0	6.0	66.0	0.0	20.0	0.0	23.0	0.0	54.0	6.0	44.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	27.0	27.0	27.0	33.0	72.0	72.0	27.0	33.0	0.0	0.0	0.0	0.0	27.0	27.0	27.0	3.0
10	PRE-SERVICE																						
11	Start: Following visit when decision for surgery or procedure made																						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA					5	5			5	5							5	5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA					3	10			3	10							3	10		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA						5				5								5		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA					7	7			7	7							7	7		
16	Follow-up phone calls & prescriptions	L037D						3	3			3	3							3	3		
17	End: When patient enters office/facility for surgery/procedure																						
18	SERVICE PERIOD																						
19	Start: When patient enters office/facility for surgery/procedure:																						
20	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA					3		3		3		3						3		3	
21	Obtain vital signs	L037D	RN/LPN/MTA					3		3		3		3						3		3	
22	Provide pre-service education/obtain consent																						
23	Prepare room, equipment, supplies	L037D	RN/LPN/MTA					2		2		2		2						2		2	
24	Setup scope (non facility setting only)																						
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA					2		2		2		2						2		2	
26	Sedate/apply anesthesia	L037D	RN/LPN/MTA			0		2		2		2		2				0		2		2	
27	Intra-service																						
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	15		20		29		30		30		33		20		23		26		26	

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1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
29	**Post-Service**																						
30	Monitor pt. following service/check tubes, monitors, drains																						
31	Clean room/equipment by physician staff	L037D	RN/LPN/MTA					3		3		3		3						3		3	
32	Clean Surgical Instrument Package	L037D						**10**		**10**		**15**		**15**						**10**		**10**	
33	Complete diagnostic forms, lab & X-ray requisitions																						
34	/prescriptions	L037D						3		3		3		3						3		3	
35	Other Clinical Activity - *specify:*	L037D							6				6								6		
36	**End: Patient leaves office**																						
37	**POST-SERVICE Period**																						
38	**Start: Patient leaves office/facility**																						
39	Conduct phone calls/call in prescriptions																						
40	***Office visits: List Number and Level of Office Visits***					# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
41	Discharge day mgmt - same day (eg, 0.5 x 99238)		6			n/a				n/a	1			n/a	1			n/a				n/a	1
42	Discharge day mgmt - 99238		12			n/a				n/a				n/a				n/a				n/a	
43	Discharge day mgmt - 99239		15			n/a				n/a				n/a				n/a				n/a	
44	99211 16 minutes		16																				
45	99212 27 minutes		27					1	1	1	1			1	1					1	1	1	1
46	99213 36 minutes		36	0		0	0					2	2										
47	99214 53 minutes		53																				
48	99215 63 minutes		63																				
49	**Total Office Visit Time**			0	0	0	0	27	27	27	33	72	72	27	33	0	0	0	0	27	27	27	33
50	Other Clinical Activity - *specify:*																						
51	**End: with last office visit before end of global period**																						

Tab: 37AAD Revised 04/26/12

	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
52	**MEDICAL SUPPLIES**	**CODE**	UNIT																				
53	pack, minimum multi-specialty visit	SA048	pack					**2**	**1**	**2**	**1**	**3**	**2**	**2**	**1**					**2**	**1**	**2**	**1**
54	pack, post-op incision care (suture)	SA054	pack					**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**					**1**	**1**	**1**	**1**
55	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item			1				1				1				1				1	
56	scrub brush (impregnated)	SM023	item					**2**		**2**		**2**		**2**						**2**		**2**	
57	mask, surgical, with face shield	SB034	item					**2**		**1**		**2**		**1**						**2**		**1**	
58	gown, staff, impervious	SB027	item					**2**		**0**		**2**		**0**						**2**		**0**	
59	gown, surgical, sterile (for physician)	SB028	item							1				1								1	
60	gown, patient	SB026	item							0				0								0	
61	cap, surgical	SB001	item					**2**		**2**		**2**		**2**						**2**		**2**	
62	gloves, non-sterile, nitrile	SB023	pair							**0**				**0**								**0**	
63	gloves, sterile	SB024	pair					**2**		**2**		**2**		**2**						**2**		**2**	
64	skin marking pen, sterile (Skin Skribe)	SK075	item							1				1								1	
65	shoe covers, surgical	SB039	pair					**2**		**2**		**2**		**2**						**2**		**2**	
66	drape, sterile, for Mayo stand	SB012	item					1		1		1		1						1		1	
67	drape, sterile, u-shape	SB015	item							1				1								1	
68	drape, sterile, three-quarter sheet	SB014	item							1		1		1						?		1	
69	drape-cover, sterile, OR light handle	SB016	item					2		1		2		1						2		1	
70	povidone surgical scrub (Betadine)	SJ041	ml			5		10		0		10		0				0		10		0	
71	swab-pad, alcohol	SJ053	item			1		2		2		2		3				1		2		2	
72	applicator, cotton-tipped, sterile, 6in	SG081	item			5				5				10				5				5	
73	syringe 20 ml	SC053	ITEM					1				1								1			
74	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item			2				2				3				2				2	

Tab: 37AAD Revised 04/26/12

	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	GLOBAL PERIOD			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
75	needle, 18-27g	SC029	item					1		0		1		0						1		0	
76	needle, 30g	SC031	item			2		1		2		1		3				2		1		2	
77	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml			8cc		20		8cc		20cc		12cc				8cc		20cc		8cc	
78	scalpel, safety, surgical, with blade (#10-20)	SF033	item			1		1		1		1		1				1		1		1	
79	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		2		2		1		1		1		1	
80	drape-towel, sterile OR blue (2 pk uou)	SB020	item					2												2			
81	suture, nylon, 4-0 to 6-0, p, ps (1/2/1)	SF037	item	1		1		1		1		2		2		1		1		1		1	
82	suture, vicryl, 3-0 to 6-0, p, ps (1/2/1)	SF040	item	1		1		1		1		2		2		1		1		1		1	
83	cautery, patient ground pad w-cord	SF021	item					1		1		1		1						1		1	
84	tape, surgical paper 1in (Micropore)	SG079	inch	24		24		12		12		24		24		24		24		12		12	
85	steri-strip (6 strip uou)	SG074	item			1				1				2								1	
86	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		2		2		1		1		1		1	
87	dressing, 3in x 4in (Telfa, Release)	SG035	item					1		1		2		2						1		1	
88	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item							1				1								1	
89	cautery, monopolar, electrode tip	SF016	item					1		0		1		0						1		1	
90	pack, cleaning, surgical instruments	SA043	pack							1				1								1	
91	cautery, monopolar, pencil-handpiece	SF020	item							1				1								1	
92	Electrocautery Supply Pack	SF016	pack			0				1				1				0				0	
93	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item							3				3								3	

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	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	GLOBAL PERIOD			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
94	EQUIPMENT	CODE																					
95	light, surgical	EF014		30				45		27		50		27		35				30		27	
96	table, exam	EF023						45		27		50		27						30		27	
97	mayo stand	EF015				20				48				51				23				51	
98	electrosurgical generator, up to 120 watts	EQ114		30		20		45		48		50		51		35		23		30		44	
99	table, power	EF031		30		20		45		48		50		51		35		23		30		44	
100	instrument pack, basic ($500-$1499)	EQ137				20		45		55				58				23		30		44	
101	Smoke Evacuator(tubing, covering, etc.) with stand	EQ351				20				48				51				23				44	
102	Digital Camera Pkg - 6 megapixel medical grade	ED004						45				50								30			

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**111.0**	**63.0**	**85.0**	**33.0**	**127.0**	**48.0**	**88.0**	**33.0**	**30.0**	**0.0**	**30.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**18.0**	**30.0**	**0.0**	**0.0**	**18.0**	**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**66.0**	**6.0**	**58.0**	**0.0**	**82.0**	**6.0**	**61.0**	**0.0**	**30.0**	**0.0**	**30.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**27.0**	**27.0**	**27.0**	**33.0**	**27.0**	**27.0**	**27.0**	**33.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5			5	5						
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10			3	10						
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5				0						
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7			7	0						
16	Follow-up phone calls & prescriptions	L037D		3	3			3	0						
17	**End: When patient enters office/facility for surgery/procedure**														
18	**SERVICE PERIOD**														
19	**Start: When patient enters office/facility for surgery/procedure:**														
20	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3		3		3					
21	Obtain vital signs	L037D	RN/LPN/MTA	3		3		3		3					
22	Provide pre-service education/obtain consent														
23	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2		2					
24	Setup scope (non facility setting only)														
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2		2					
26	Sedate/apply anesthesia	L037D	RN/LPN/MTA	2		2		2		2				0	
27	**Intra-service**														
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	38		30		49		33		30		30	

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
29	**Post-Service**														
30	Monitor pt. following service/check tubes, monitors, drains														
31	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3		3					
32	Clean Surgical Instrument Package	L037D		**10**		**10**		**15**		**10**					
33	Complete diagnostic forms, lab & X-ray requisitions														
34	Check dressings or wound home care instructions/coordinate office visits /prescriptions	L037D		**3**		**3**		**3**		**3**					
35	Other Clinical Activity - *specify:*	L037D			6				6						
36	**End: Patient leaves office**														
37	**POST-SERVICE Period**														
38	**Start: Patient leaves office/facility**														
39	Conduct phone calls/call in prescriptions														
40	***Office visits: List Number and Level of Office Visits***					# visits	# visits			# visits	# visits			# visits	# visits
41	Discharge day mgmt - same day (eg, 0.5 x 99238)		6			n/a	1			n/a	1			n/a	
42	Discharge day mgmt - 99238		12			n/a				n/a				n/a	
43	Discharge day mgmt - 99239		15			n/a				n/a				n/a	
44	99211 16 minutes		16												
45	99212 27 minutes		27	1	1	1	1	1	1	1	1				
46	99213 36 minutes		36												
47	99214 53 minutes		53												
48	99215 63 minutes		63												
49	**Total Office Visit Time**			**27**	**27**	**27**	**33**	**27**	**27**	**27**	**33**	**0**	**0**	**0**	**0**
50	Other Clinical Activity - *specify:*														
51	**End: with last office visit before end of global period**														

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	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
52	**MEDICAL SUPPLIES**	**CODE**	UNIT												
53	pack, minimum multi-specialty visit	SA048	pack	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**				
54	pack, post-op incision care (suture)	SA054	pack	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**				
55	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item			1				1				1	
56	scrub brush (impregnated)	SM023	item	**2**		**2**		**2**		**2**					
57	mask, surgical, with face shield	SB034	item	**2**		**1**		**2**		1					
58	gown, staff, impervious	SB027	item	**2**		**0**		**2**		0					
59	gown, surgical, sterile (for physician)	SB028	item			1				1					
60	gown, patient	SB026	item			0				0					
61	cap, surgical	SB001	item	**2**		**2**		**2**		2					
62	gloves, non-sterile, nitrile	SB023	pair			**0**				**0**					
63	gloves, sterile	SB024	pair	**2**		**2**		**2**		**2**					
64	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1					
65	shoe covers, surgical	SB039	pair	**2**		**2**		**2**		**2**					
66	drape, sterile, for Mayo stand	SB012	item	1		1		1		1					
67	drape, sterile, u-shape	SB015	item			1				1					
68	drape, sterile, three-quarter sheet	SB014	item	?		1		1		1					
69	drape-cover, sterile, OR light handle	SB016	item	2		1		2		1					
70	povidone surgical scrub (Betadine)	SJ041	ml	10		0		10		0				0	
71	swab-pad, alcohol	SJ053	item			2		2		3				1	
72	applicator, cotton-tipped, sterile, 6in	SG081	item			5				10				5	
73	syringe 20 ml	SC053	ITEM	1				1							
74	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	0		2		0		3				2	

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13151		13151		13152		13152		13153		13153	
3	**Meeting Date: April 2012** **Tab: 37** **Specialty:AAD/ASPS/AAO-HNS**	**CMS Code**	Staff Type	**Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**		**Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**		**Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**		**Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**		***Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)***		***Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary***	
4	**LOCATION**					**Non Fac**	**Fac**	**Non Fac**	**Fac**	**Non Fac**	**Fac**	**Non Fac**	**Fac**	**Non Fac**	**Fac**
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
75	needle, 18-27g	SC029	item	1		1		1						0	
76	needle, 30g	SC031	item	1		2		1		3				2	
77	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml	20cc		8cc		20cc		12cc				8cc	
78	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1				1	
79	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		2		2		1		1	
80	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2											
81	suture, nylon, 4-0 to 6-0, p, ps (1/2/1)	SF037	item	1		1		2		2		1		1	
82	suture, vicryl, 3-0 to 6-0, p, ps (1/2/1)	SF040	item	1		1		2		2		1		1	
83	cautery, patient ground pad w-cord	SF021	item	1		1		1							
84	tape, surgical paper 1in (Micropore)	SG079	inch			12		24		24		24		24	
85	steri-strip (6 strip uou)	SG074	item			1				2					
86	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		2		1		1	
87	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		2		2					
88	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1					
89	cautery, monopolar, electrode tip	SF016	item	1		1		1		0				0	
90	pack, cleaning, surgical instruments	SA043	pack			1		1		1					
91	cautery, monopolar, pencil-handpiece	SF020	item			1				1					
92	Electrocautery Supply Pack	SF016	pack			0				1				1	
93	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3					

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	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE		CURRENT PE INPUTS		SURVEY CODE	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
94	**EQUIPMENT**	**CODE**													
95	light, surgical	EF014		45		27		50		27		45			
96	table, exam	EF023		45		27		50		27					
97	mayo stand	EF015				48				51				30	
98	electrosurgical generator, up to 120 watts	EQ114		45		48		50		51		45		30	
99	table, power	EF031				48		50		51		45		30	
100	instrument pack, basic ($500-$1499)	EQ137		45		55				58				30	
101	Smoke Evacuator(tubing, covering, etc.) with stand	EQ351				48				51				30	
102	Digital Camera Pkg - 6 megapixel medical grade	ED004		45				50							

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**95.0**	**63.0**	**76.0**	**33.0**	**113.0**	**63.0**	**89.0**	**33.0**	**17.0**	**0.0**	**20.0**	**0.0**	**96.0**	**63.0**	**78.0**	**33.0**	**145.0**	**90.0**	**90.0**	**33.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**18.0**	**30.0**	**0.0**	**0.0**	**18.0**	**30.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**18.0**	**30.0**	**0.0**	**0.0**	**18.0**	**30.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**50.0**	**6.0**	**49.0**	**0.0**	**68.0**	**6.0**	**62.0**	**0.0**	**17.0**	**0.0**	**20.0**	**0.0**	**51.0**	**6.0**	**51.0**	**0.0**	**73.0**	**6.0**	**63.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**27.0**	**27.0**	**27.0**	**33.0**	**27.0**	**27.0**	**27.0**	**33.0**	**0.0**	**0.0**	**0.0**	**0.0**	**27.0**	**27.0**	**27.0**	**33.0**	**54.0**	**54.0**	**27.0**	**33.0**
10	**PRE-SERVICE**																						
11	**Start: Following visit when decision for surgery or procedure made**																						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		**5**			**5**	**10**							5	10			5	5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**5**	**5**			**3**	**3**							3	3			3	10		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	**3**	**3**																5		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**7**	**7**			**7**	**7**							7	7			7	7		
16	Follow-up phone calls & prescriptions	L037D		**3**	**10**			**3**	**10**							3	10			3	3		
17	**End: When patient enters office/facility for surgery/procedure**																						
18	**SERVICE PERIOD**																						
19	**Start: When patient enters office/facility for surgery/procedure:**																						
20	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	**3**		**3**		**3**		3						3		3		3		3	
21	Obtain vital signs	L037D	RN/LPN/MTA	**3**		**3**		**3**		3						3		3		3		3	
22	Provide pre-service education/obtain consent																			2			
23	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**		**2**		2						2		2		2		2	
24	Setup scope (non facility setting only)																						
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**2**		**2**		**2**		2						2		2		2		2	
26	Sedate/apply anesthesia	L037D	RN/LPN/MTA	**2**		**2**		**2**		2				0		2		2		2		2	
27	**Intra-service**																						
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	**22**		**21**		**35**		29		17		20		23		23		38		30	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
29	**Post-Service**																						
30	Monitor pt. following service/check tubes, monitors, drains																						
31	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**		**3**		3						3		3		3		3	
32	Clean Surgical Instrument Package	L037D		**10**		**10**		**15**		15						10		**10**		**15**		**15**	
33	Complete diagnostic forms, lab & X-ray requisitions																						
34	~~Check dressings & wound home care instructions/estimate office visits~~ /prescriptions	L037D		**3**		**3**		**3**		3						3		**3**		**3**		**3**	
35	Other Clinical Activity - *specify:*	L037D			**6**				**6**								6				6		
36	**End: Patient leaves office**																						
37	**POST-SERVICE Period**																						
38	**Start: Patient leaves office/facility**																						
39	Conduct phone calls/call in prescriptions																						
40	***Office visits: List Number and Level of Office Visits***			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
41	Discharge day mgmt - same day (eg, 0.5 x 99238)		6	**n/a**		**n/a**	**1**	**n/a**		**n/a**	**1**			**n/a**				**n/a**	**1**			**n/a**	**1**
42	Discharge day mgmt - 99238		12	**n/a**		**n/a**		**n/a**		**n/a**				**n/a**				**n/a**				**n/a**	
43	Discharge day mgmt - 99239		15	**n/a**		**n/a**		**n/a**		**n/a**				**n/a**				**n/a**				**n/a**	
44	99211 16 minutes		16																				
45	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**					**1**	**1**	**1**	**1**	**2**	**2**	**1**	**1**
46	99213 36 minutes		36																				
47	99214 53 minutes		53																				
48	99215 63 minutes		63																				
49	**Total Office Visit Time**			**27**	**27**	**27**	**33**	**27**	**27**	**27**	**33**	**0**	**0**	**0**	**0**	**27**	**27**	**27**	**33**	**54**	**54**	**27**	**33**
50	Other Clinical Activity - *specify:*																						
51	**End: with last office visit before end of global period**																						

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
52	**MEDICAL SUPPLIES**	**CODE**	UNIT																				
53	pack, minimum multi-specialty visit	SA048	pack	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**					**2**	**1**	**2**	**1**	**3**	**2**	**2**	**1**
54	pack, post-op incision care (suture)	SA054	pack	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**					**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
55	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item			**1**				1				1				1				1	
56	scrub brush (impregnated)	SM023	item	**2**		**2**		**2**		2						2		**2**		**2**		**2**	
57	mask, surgical, with face shield	SB034	item	**2**		**2**		**2**		**2**	**2**					**2**		**2**	**2**	**2**		**2**	
58	gown, staff, impervious	SB027	item	**2**		**2**		**2**		2	2					2		**2**	**2**	**2**		**2**	
59	gown, surgical, sterile (for physician)	SB028	item			**1**				1	1							1	1			1	
60	gown, patient	SB026	item			**0**				0	0							0	0			0	
61	cap, surgical	SB001	item	**2**		**2**		**2**		2	2					2		**2**	**2**	**2**		**2**	
62	gloves, non-sterile, nitrile	SB023	pair			**0**				**0**	**0**							**0**	**0**			**0**	
63	gloves, sterile	SB024	pair	**2**		**2**		**2**		**2**	**2**					**2**		**2**	**2**	**2**		**2**	
64	skin marking pen, sterile (Skin Skribe)	SK075	item			**1**				1	1							1	1			1	
65	shoe covers, surgical	SB039	pair	**2**		**2**		**2**		**2**	**2**					**2**		**2**	**2**	**2**		**2**	
66	drape, sterile, for Mayo stand	SB012	item	**1**		**1**		**1**		1	1					1		1	1	1		1	
67	drape, sterile, u-shape	SB015	item			**1**				1								1				1	
68	drape, sterile, three-quarter sheet	SB014	item			**1**		**1**		1								1		1		1	
69	drape-cover, sterile, OR light handle	SB016	item	**1**		**2**		**2**		2						2		2		2		2	
70	povidone surgical scrub (Betadine)	SJ041	ml	**10**		**5**		**10**		10				5		10		5		10		10	
71	swab-pad, alcohol	SJ053	item	**2**		**2**		**2**		3				1		2		2		2		3	
72	applicator, cotton-tipped, sterile, 6in	SG081	item			**5**				10				5				5				10	
73	syringe 20 ml	SC053	ITEM	**1**				**1**								1				1			
74	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item			**2**				3				2		1		2				3	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
75	needle, 18-27g	SC029	item	**1**		**1**		**1**		1						1		1		1		1	
76	needle, 30g	SC031	item	**1**		**2**		**1**		3				2		1		2		1		3	
77	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml	**20cc**		**8cc**		**20cc**		12cc				8cc		20cc		8cc		20cc		12cc	
78	scalpel, safety, surgical, with blade (#10-20)	SF033	item	**1**		**1**		**1**		1				1		1		1		1		1	
79	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
80	drape-towel, sterile OR blue (2 pk uou)	SB020	item	**2**												2							
81	suture, nylon, 4-0 to 6-0, p, ps (1/2/1)	SF037	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
82	suture, vicryl, 3-0 to 6-0, p, ps (1/2/1)	SF040	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
83	cautery, patient ground pad w-cord	SF021	item	**1**		**1**		**1**		1						1		1		1		1	
84	tape, surgical paper 1in (Micropore)	SG079	inch	**12**		**12**		**24**		24		24		24		12		12		24		24	
85	steri-strip (6 strip uou)	SG074	item			**1**				2				1				1				2	
86	bacitracin oint (0.9gm uou)	SJ007	item	**1**		**1**		**2**		2		1		1		1		1		2		2	
87	dressing, 3in x 4in (Telfa, Release)	SG035	item	**1**		**1**		**2**		2						1		1		2		2	
88	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			**1**				1								1				1	
89	cautery, monopolar, electrode tip	SF016	item	**1**		**1**		**1**		1						1		1		1		1	
90	pack, cleaning, surgical instruments	SA043	pack			**1**				1								1				1	
91	cautery, monopolar, pencil-handpiece	SF020	item			**1**				1								1				1	
92	Electrocautery Supply Pack	SF016	pack			**1**				1				1				1				1	
93	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			**3**				3								3				3	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13100		13100		13101		13101		13102		13102		13120		13120		13121		13121	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 1.1 cm to 2.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		Repair, complex, trunk; 2.6 cm to 7.5 cm		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, trunk; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Facy	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			**10**	**10**	**10**	**10**	**10**	**10**	10	10	10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10
94	**EQUIPMENT**	**CODE**																					
95	light, surgical	EF014		**32**		**32**		**45**		45		30				86		86		129		129	
96	table, exam	EF023		**32**				**45**								86				129			
97	mayo stand	EF015				**32**				45								86				129	
98	electrosurgical generator, up to 120 watts	EQ114		**32**		**32**		**45**		45		30		30		86		86		129		129	
99	table, power	EF031		**32**		**32**		**45**		45		30				86		86		129		129	
100	instrument pack, basic ($500-$1499)	EQ137		**32**		**32**				45						86		86				129	
101	*Smoke Evacuator(tubing, covering, etc.) (invoice to be supplied)*					32				45								86				129	
102	Digital Camera Pkg - 6 megapixel medical grade	ED004		32				45								86				129			

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	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	GLOBAL PERIOD			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	15.0	0.0	20.0	0.0	102.0	63.0	85.0	33.0	153.0	108.0	93.0	33.0	20.0	0.0	23.0	0.0	99.0	63.0	75.0	33.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	18.0	30.0	0.0	0.0	18.0	30.0	0.0	0.0	0.0	0.0	0.0	0.0	18.0	30.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	15.0	0.0	20.0	0.0	57.0	6.0	58.0	0.0	63.0	6.0	66.0	0.0	20.0	0.0	23.0	0.0	54.0	6.0	48.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	27.0	27.0	27.0	33.0	72.0	72.0	27.0	33.0	0.0	0.0	0.0	0.0	27.0	27.0	27.0	33.0
10	PRE-SERVICE																						
11	Start: Following visit when decision for surgery or procedure made																						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA					5	5			5	5							5	5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA					3	10			3	10							3	10		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA						5				5								5		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA					7	7			7	7							7	7		
16	Follow-up phone calls & prescriptions	L037D						3	3			3	3							3	3		
17	End: When patient enters office/facility for surgery/procedure																						
18	SERVICE PERIOD																						
19	Start: When patient enters office/facility for surgery/procedure:																						
20	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA					3		3		3		3						3		3	
21	Obtain vital signs	L037D	RN/LPN/MTA					3		3		3		3						3		3	
22	Provide pre-service education/obtain consent																						
23	Prepare room, equipment, supplies	L037D	RN/LPN/MTA					2		2		2		2						2		2	
24	Setup scope (non facility setting only)																						
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA					2		2		2		2						2		2	
26	Sedate/apply anesthesia	L037D	RN/LPN/MTA			0		2		2		2		2				0		2		2	
27	Intra-service																						
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	15		20		29		30		30		33		20		23		26		20	

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	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
29	**Post-Service**																						
30	Monitor pt. following service/check tubes, monitors, drains																						
31	Clean room/equipment by physician staff	L037D	RN/LPN/MTA					3		3		3		3						3		3	
32	Clean Surgical Instrument Package	L037D						**10**		**10**		**15**		**15**						**10**		**10**	
33	Complete diagnostic forms, lab & X-ray requisitions																						
34	Check dressings or wound home care instructions recordmate office visits /prescriptions	L037D						**3**		**3**		**3**		**3**						**3**		**3**	
35	Other Clinical Activity - *specify:*	L037D							6				6								6		
36	**End: Patient leaves office**																						
37	**POST-SERVICE Period**																						
38	**Start: Patient leaves office/facility**																						
39	Conduct phone calls/call in prescriptions																						
40	***Office visits: List Number and Level of Office Visits***					# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits
41	Discharge day mgmt - same day (eg, 0.5 x 99238)		6			n/a				n/a	1			n/a	1			n/a				n/a	1
42	Discharge day mgmt - 99238		12			n/a				n/a				n/a				n/a				n/a	
43	Discharge day mgmt - 99239		15			n/a				n/a				n/a				n/a				n/a	
44	99211 16 minutes		16																				
45	99212 27 minutes		27					1	1	1	1			1	1					1	1	1	1
46	99213 36 minutes		36	0		0	0					2	2										
47	99214 53 minutes		53																				
48	99215 63 minutes		63																				
49	**Total Office Visit Time**			0	0	0	0	27	27	27	33	72	72	27	33	0	0	0	0	27	27	27	33
50	Other Clinical Activity - *specify:*																						
51	**End: with last office visit before end of global period**																						

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	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	GLOBAL PERIOD			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
52	MEDICAL SUPPLIES	CODE	UNIT																				
53	pack, minimum multi-specialty visit	SA048	pack					2	1	2	1	3	2	2	1					2	1	2	1
54	pack, post-op incision care (suture)	SA054	pack					1	1	1	1	1	1	1	1					1	1	1	1
55	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item			1				1				1				1				1	
56	scrub brush (impregnated)	SM023	item					2		2		2		2						2		2	
57	mask, surgical, with face shield	SB034	item					2		2		2		2						2		2	
58	gown, staff, impervious	SB027	item					2		2		2		2						2		2	
59	gown, surgical, sterile (for physician)	SB028	item							1				1								1	
60	gown, patient	SB026	item							0				0								0	
61	cap, surgical	SB001	item					2		2		2		2						2		2	
62	gloves, non-sterile, nitrile	SB023	pair							0				0								0	
63	gloves, sterile	SB024	pair					2		2		2		2						2		2	
64	skin marking pen, sterile (Skin Skribe)	SK075	item							1				1								1	
65	shoe covers, surgical	SB039	pair					2		2		2		2						2		2	
66	drape, sterile, for Mayo stand	SB012	item					1		1		1		1						1		1	
67	drape, sterile, u-shape	SB015	item							1				1								1	
68	drape, sterile, three-quarter sheet	SB014	item							1		1		1						?		1	
69	drape-cover, sterile, OR light handle	SB016	item					2		2		2		2						2		2	
70	povidone surgical scrub (Betadine)	SJ041	ml			5		10		5		10		10				5		10		5	
71	swab-pad, alcohol	SJ053	item			1		2		2		2		3				1		2		2	
72	applicator, cotton-tipped, sterile, 6in	SG081	item			5				5				10				5				5	
73	syringe 20 ml	SC053	ITEM					1				1								1			
74	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item			2				2				3				2				2	

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2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, scalp, arms, and/or legs; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		*Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each addtl 5 cm or less (List sep in addition to code for primary procedure)*		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	
4	**LOCATION**			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
75	needle, 18-27g	SC029	item					1		1		1		1						1		1	
76	needle, 30g	SC031	item			2		1		2		1		3				2		1		2	
77	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml			8cc		20		8cc		20cc		12cc				8cc		20cc		8cc	
78	scalpel, safety, surgical, with blade (#10-20)	SF033	item			1		1		1		1		1				1		1		1	
79	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		2		2		1		1		1		1	
80	drape-towel, sterile OR blue (2 pk uou)	SB020	item					2												2			
81	suture, nylon, 4-0 to 6-0, p, ps (1/2/1)	SF037	item	1		1		1		1		2		2		1		1		1		1	
82	suture, vicryl, 3-0 to 6-0, p, ps (1/2/1)	SF040	item	1		1		1		1		2		2		1		1		1		1	
83	cautery, patient ground pad w-cord	SF021	item					1		1		1		1						1		1	
84	tape, surgical paper 1in (Micropore)	SG079	inch	24		24		12		12		24		24		24		24		12		12	
85	steri-strip (6 strip uou)	SG074	item			1				1				2								1	
86	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		2		2		1		1		1		1	
87	dressing, 3in x 4in (Telfa, Release)	SG035	item					1		1		2		2						1		1	
88	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item							1				1								1	
89	cautery, monopolar, electrode tip	SF016	item					1		1		1		1						1		1	
90	pack, cleaning, surgical instruments	SA043	pack							1				1								1	
91	cautery, monopolar, pencil-handpiece	SF020	item							1				1								1	
92	Electrocautery Supply Pack	SF016	pack			1				1				1				1				1	
93	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item							3				3								3	

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1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE		CURRENT PE		SURVEY CODE	
2				13122		13122		13131		13131		13132		13132		13133		13133		13150		13150	
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4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac			Non Fac	Fac
5	GLOBAL PERIOD			10	10	ZZZ	ZZZ	10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ	10	10	10	10
94	EQUIPMENT	CODE																					
95	light, surgical	EF014		30				45		45		50		50		35				30		30	
96	table, exam	EF023						45				50								30			
97	mayo stand	EF015								45				50								30	
98	electrosurgical generator, up to 120 watts	EQ114		30		30		45		45		50		50		35		35		30		30	
99	table, power	EF031		30				45		45		50		50		35				30		30	
100	instrument pack, basic ($500-$1499)	EQ137						45		45				50						30		30	
101	*Smoke Evacuator(tubing, covering, etc.) (invoice to be supplied)*									45				50								30	
102	Digital Camera Pkg - 6 megapixel medical grade	ED004						45				50								30			

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	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**111.0**	**63.0**	**85.0**	**33.0**	**127.0**	**48.0**	**93.0**	**33.0**	**30.0**	**0.0**	**30.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**18.0**	**30.0**	**0.0**	**0.0**	**18.0**	**15.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**66.0**	**6.0**	**58.0**	**0.0**	**82.0**	**6.0**	**66.0**	**0.0**	**30.0**	**0.0**	**30.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**27.0**	**27.0**	**27.0**	**33.0**	**27.0**	**27.0**	**27.0**	**33.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5			5	5						
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10			3	10						
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5				0						
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7			7	0						
16	Follow-up phone calls & prescriptions	L037D		3	3			3	0						
17	**End: When patient enters office/facility for surgery/procedure**														
18	**SERVICE PERIOD**														
19	**Start: When patient enters office/facility for surgery/procedure:**														
20	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3		3		3					
21	Obtain vital signs	L037D	RN/LPN/MTA	3		3		3		3					
22	Provide pre-service education/obtain consent														
23	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2		2					
24	Setup scope (non facility setting only)														
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2		2					
26	Sedate/apply anesthesia	L037D	RN/LPN/MTA	2		2		2		2				0	
27	**Intra-service**														
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	38		30		49		33		30		30	

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
29	**Post-Service**														
30	Monitor pt. following service/check tubes, monitors, drains														
31	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3		3					
32	Clean Surgical Instrument Package	L037D		**10**		**10**		**15**		**15**					
33	Complete diagnostic forms, lab & X-ray requisitions														
34	Check dressings or wound home care instructions recordmate office visits /prescriptions	L037D		**3**		**3**		**3**		**3**					
35	Other Clinical Activity - *specify:*	L037D			6				6						
36	**End: Patient leaves office**														
37	**POST-SERVICE Period**														
38	**Start: Patient leaves office/facility**														
39	Conduct phone calls/call in prescriptions														
40	***Office visits: List Number and Level of Office Visits***					# visits	# visits			# visits	# visits			# visits	# visits
41	Discharge day mgmt - same day (eg, 0.5 x 99238)		6			n/a	1			n/a	1			n/a	
42	Discharge day mgmt - 99238		12			n/a				n/a				n/a	
43	Discharge day mgmt - 99239		15			n/a				n/a				n/a	
44	99211 16 minutes		16												
45	99212 27 minutes		27	1	1	1	1	1	1	1	1				
46	99213 36 minutes		36												
47	99214 53 minutes		53												
48	99215 63 minutes		63												
49	**Total Office Visit Time**			**27**	**27**	**27**	**33**	**27**	**27**	**27**	**33**	**0**	**0**	**0**	**0**
50	Other Clinical Activity - *specify:*														
51	**End: with last office visit before end of global period**														

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
52	**MEDICAL SUPPLIES**	**CODE**	UNIT												
53	pack, minimum multi-specialty visit	SA048	pack	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**				
54	pack, post-op incision care (suture)	SA054	pack	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**				
55	drape, sterile, fenestrated 16in x 16in (eye)	SB010	item			1				1				1	
56	scrub brush (impregnated)	SM023	item	**2**		**2**		**2**		**2**					
57	mask, surgical, with face shield	SB034	item	**2**		**2**		**2**		2					
58	gown, staff, impervious	SB027	item	**2**		**2**		**2**		2					
59	gown, surgical, sterile (for physician)	SB028	item			1				1					
60	gown, patient	SB026	item			0				0					
61	cap, surgical	SB001	item	**2**		**2**		**2**		2					
62	gloves, non-sterile, nitrile	SB023	pair			**0**				**0**					
63	gloves, sterile	SB024	pair	**2**		**2**		**2**		**2**					
64	skin marking pen, sterile (Skin Skribe)	SK075	item			1				1					
65	shoe covers, surgical	SB039	pair	**2**		**2**		**2**		**2**					
66	drape, sterile, for Mayo stand	SB012	item	1		1		1		1					
67	drape, sterile, u-shape	SB015	item			1				1					
68	drape, sterile, three-quarter sheet	SB014	item	?		1		1		1					
69	drape-cover, sterile, OR light handle	SB016	item	2		2		2		2					
70	povidone surgical scrub (Betadine)	SJ041	ml	10		5		10		10				5	
71	swab-pad, alcohol	SJ053	item			2		2		3				1	
72	applicator, cotton-tipped, sterile, 6in	SG081	item			5				10				5	
73	syringe 20 ml	SC053	ITEM	1				1							
74	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	0		2		0		3				2	

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13151		13151		13152		13152		13153		13153	
3	**Meeting Date: April 2012** **Tab: 37** **Specialty:AAD/ASPS/AAO-HNS**	**CMS Code**	Staff Type	**Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**		**Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**		**Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**		**Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**		***Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)***		***Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary***	
4	**LOCATION**					**Non Fac**	**Fac**	**Non Fac**	**Fac**	**Non Fac**	**Fac**	**Non Fac**	**Fac**	**Non Fac**	**Fac**
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
75	needle, 18-27g	SC029	item	1		1		1						2	
76	needle, 30g	SC031	item	1		2		1		3				2	
77	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml	20cc		8cc		20cc		12cc				8cc	
78	scalpel, safety, surgical, with blade (#10-20)	SF033	item	1		1		1		1				1	
79	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		2		2		1		1	
80	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2											
81	suture, nylon, 4-0 to 6-0, p, ps (1/2/1)	SF037	item	1		1		2		2		1		1	
82	suture, vicryl, 3-0 to 6-0, p, ps (1/2/1)	SF040	item	1		1		2		2		1		1	
83	cautery, patient ground pad w-cord	SF021	item	1		1		1							
84	tape, surgical paper 1in (Micropore)	SG079	inch			12		24		24		24		24	
85	steri-strip (6 strip uou)	SG074	item			1				2					
86	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		2		1		1	
87	dressing, 3in x 4in (Telfa, Release)	SG035	item	1		1		2		2					
88	adhesive liquid (Mastisol) (0.67ml uou)	SG004	item			1				1					
89	cautery, monopolar, electrode tip	SF016	item	1		1		1		1					
90	pack, cleaning, surgical instruments	SA043	pack			1		1		1					
91	cautery, monopolar, pencil-handpiece	SF020	item			1				1					
92	Electrocautery Supply Pack	SF016	pack			1				1				1	
93	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			3				3					

Tab: 37AAD Revised 04/26/12

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC
1				CURRENT PE		SURVEY		CURRENT PE		SURVEY		CURRENT PE		SURVEY	
2				13151		13151		13152		13152		13153		13153	
3	Meeting Date: April 2012 Tab: 37 Specialty:AAD/ASPS/AAO-HNS	CMS Code	Staff Type	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary procedure)*		*Repair, complex, eyelids, nose, ears and/or lips; each addtl 5 cm or less (List separately in addition to code for primary*	
4	**LOCATION**					Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	**GLOBAL PERIOD**			10	10	10	10	10	10	10	10	10	10	ZZZ	ZZZ
94	**EQUIPMENT**	**CODE**													
95	light, surgical	EF014		45		45		50		50		45			
96	table, exam	EF023		45				50							
97	mayo stand	EF015				45				50					
98	electrosurgical generator, up to 120 watts	EQ114		45		45		50		50		45		45	
99	table, power	EF031				45		50		50		45			
100	instrument pack, basic ($500-$1499)	EQ137		45		45				50					
101	*Smoke Evacuator(tubing, covering, etc.) (invoice to be supplied)*					45				50					
102	Digital Camera Pkg - 6 megapixel medical grade	ED004		45				50							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes screen

April 2012

Arthrocentesis-PE Only

This service was identified by CMS in July 2011 through the CMS High Expenditure Procedural Codes screen. Surveys for physician work were reviewed recently for the 2011 Medicare physician payment schedule, but practice expense was not reviewed at that time. In January 2012, the RUC recommended that the practice expense only be reviewed at the April 2012 meeting. The Practice Expense Subcommittee removed three minutes for *provide pre-service education/obtain consent* from each code because they are commonly billed with an Evaluation and Management service. **The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.**

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
20600		Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	000	0.66 (PE Input Recommendations Only)
20605		intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	000	0.68 (PE Input Recommendations Only)
20610		major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa) (If imaging guidance is performed, see 76942, 77002, 77012, 77021)	000	0.79 (PE Input Recommendations Only)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
20600, Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Global Period: 000 Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
CPT code 20610 was identified as a CMS high expenditure procedure by the RUC's Relativity Assessment Workgroup and was placed on the list for potential review. The AAOS and ASSH recommended a review of practice expense only since 20610, along with 20600 and 20605 were reviewed for work as part of the 2010 5-Year review. However, none of the 5-year review codes were reviewed for PE at the time. In our comments on the 2012 NPRM we stated to CMS, and later to the RUC RAW workgroup that another review of work would be unnecessary but that review of the 2000 PEAC practice expense inputs would be appropriate and CMS and the RUC agreed. Subsequently, a consensus committee of experts reviewed the current PE details for 20610 and recommended revised facility practice expense inputs and for rank order purposes, also recommends that 20600 and 20605 also be revised for practice expense.

The attached recommendations are for facility practice expense inputs to all three codes in the family.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:
Our consensus committee reviewed current PE details and determined that in order to be consistent with current PE subcommittee standards for facility inputs that changes were appropriate. Specifically, we are recommending revised inputs for clinical labor time for all three codes with 6 minutes of total clinical labor time for intra-service discharge related work. This is appropriate because all three procedures are billed more than 50% of the time with an E/M service on the same day of service and therefore the pre and post-service clinical labor time is accounted for in the E/M codes and doesn't need to be included in the procedure's PE.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

none

Intra-Service Clinical Labor Activities:

Same day discharge management

Post-Service Clinical Labor Activities:
None (this removes 10 minutes from previous inputs to be consistent with current PE standards for facility Practice Expense).

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
20600, Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Global Period: 000 Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

CPT code 20610 was identified as a CMS high expenditure procedure by the RUC's Relativity Assessment Workgroup and was placed on the list for potential review. The AAOS and ASSH recommended a review of practice expense only since 20610, along with 20600 and 20605 were reviewed for work as part of the 2010 5-Year review. However, none of the 5-year review codes were reviewed for PE at the time. In our comments on the 2012 NPRM we stated to CMS, and later to the RUC RAW workgroup that another review of work would be unnecessary but that review of the 2000 PEAC practice expense inputs would be appropriate and CMS and the RUC agreed.

Subsequently, a consensus committee of experts reviewed the current PE details for 20610 and recommended revised non-facility practice expense inputs and for rank order purposes, also recommends that 20600 and 20605 also be revised for practice expense.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:
Our consensus committee reviewed current PE details and determined that in order to be consistent with current PE subcommittee standards for non-facility inputs that changes were appropriate. Specifically, we are recommending revised inputs for clinical labor time for all three codes with 22 total minutes of clinical labor time with zero minutes of pre-service clinical labor time; 19 minutes of total clinical labor time for intra-service related work, and three minutes of post-service clinical labor time for discharge management work. This is appropriate because all three procedures are billed more than 50% of the time with an E/M service on the same day of service and therefore the pre and post-service clinical labor time is accounted for in the E/M codes and doesn't need to be included in the procedure's PE except a minimal amount of post-discharge clinical labor time.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

none

Service Clinical Labor Activities:

We have allocated 19 minutes intra-service clinical labor time for assisting the physician which is consistent with other non-facility PE inputs when a service is performed more than 50% of the time with an E/M service and to have the same intra-service clinical labor time as the physician clinical labor time. Specifically, three minutes for obtaining patient consent and pre-service education (no change from current inputs), two minutes to prepare room, equipment and supplies (no change from current inputs), five minutes assisting physician in procedure (5 minutes less than current inputs to be consistent with the current work intra-service time of 5 minutes), three minutes to monitor patient post-service (no change from current inputs), three minutes to clean the room and equipment (no change from current inputs), and three minutes to check dressing and wounds and provide discharge management instructions (no change from current inputs).

Post-Service Clinical Labor Activities:

We have allocated 3 minutes post-service clinical labor time for follow up phone calls and to call in prescriptions (no change from current inputs). We removed 5 minutes from current inputs for other clinical activity.

	A	B	C	D	E	F	G
1				REFERENCE CODE		Billed w-E/M	
2				20600 PEAC 2000		20600 Rev. 04/12	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)		Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**34**	**10**	**19**	**3**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**26**	**0**	**16**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8**	**10**	**3**	**3**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**2**			
22	Obtain vital signs						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**0**	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**10**		**5**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
35	Complete diagnostic forms, lab & X-ray requisitions						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**	**0**
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**5**	**3**	**3**
53	Other Clinical Activity - *specify: Conduct phone calls/ lab stops completed and call lab*			**5**	**5**		
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	pack, minimum multi-specialty visit	SA048	pack	**0**			
57	drape, sterile barrier 16in x 29in	SB007	item	**1**		**1**	
58	gloves, sterile	SB024	pair	**1**		**1**	
59	povidone soln (Betadine)	SJ041	ml	**10**		**10**	
60	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**5**		**1**	
61	swab-pad, alcohol	SJ053	item			**2**	
62	needle, 18-27g	SC029	item	**2**		**2**	
63	syringe 3ml	SC055	item			**1**	
64	syringe 5-6ml	SC057	item				
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	
67	syringe 1ml	SC052	item	**1**			
68	cup, biopsy-specimen non-sterile 4oz	SL035	item	**1**			
69							
70	**EQUIPMENT**	**CODE**					
71	NO EQUIPMENT	EZ007		**0**	**0**		
72	light, exam	EQ168				**16**	**0**
73	table, exam	EF023				**16**	**0**

	A	B	C	H	I	J	K
1				REFERENCE CODE		Billed w-E/M	
2				20605 PEAC 2000		20605 Rev. 04/12	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular,		Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular,	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**34**	**10**	**19**	**3**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**26**	**0**	**16**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8**	**10**	**3**	**3**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**2**			
22	Obtain vital signs						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**0**	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**10**		**5**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
35	Complete diagnostic forms, lab & X-ray requisitions						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**	**0**
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**5**	**3**	**3**
53	Other Clinical Activity - *specify: Conduct phone calls/ lab stops completed and call lab*			**5**	**5**		
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	pack, minimum multi-specialty visit	SA048	pack				
57	drape, sterile barrier 16in x 29in	SB007	item	**1**		**1**	
58	gloves, sterile	SB024	pair	**1**		**1**	
59	povidone soln (Betadine)	SJ041	ml	**10**		**10**	
60	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**5**		**3**	
61	swab-pad, alcohol	SJ053	item			**2**	
62	needle, 18-27g	SC029	item	**2**		**2**	
63	syringe 3ml	SC055	item			**1**	
64	syringe 5-6ml	SC057	item				
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	
67	syringe 1ml	SC052	item	**1**			
68	cup, biopsy-specimen non-sterile 4oz	SL035	item	**1**			
69							
70	**EQUIPMENT**	**CODE**					
71	NO EQUIPMENT	EZ007		**0**	**0**		
72	light, exam	EQ168				**16**	**0**
73	table, exam	EF023				**16**	**0**

	A	B	C	L	M	N	O
1				REFERENCE CODE		Billed w-E/M	
2				20610 PEAC 2000		20610 Rev. 04/12	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint,		Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint,	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**34**	**10**	**19**	**3**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**26**	**0**	**16**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8**	**10**	**3**	**3**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**2**			
22	Obtain vital signs						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**0**	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**10**		**5**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
35	Complete diagnostic forms, lab & X-ray requisitions						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**	**0**
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**5**	**3**	**3**
53	Other Clinical Activity - *specify: Conduct phone calls/ lab stops completed and call lab*			**5**	**5**		
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	pack, minimum multi-specialty visit	SA048	pack				
57	drape, sterile barrier 16in x 29in	SB007	item	**1**		**1**	
58	gloves, sterile	SB024	pair	**1**		**1**	
59	povidone soln (Betadine)	SJ041	ml	**10**		**10**	
60	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**5**		**5**	
61	swab-pad, alcohol	SJ053	item			**2**	
62	needle, 18-27g	SC029	item	**2**		**2**	
63	syringe 3ml	SC055	item			**1**	
64	syringe 5-6ml	SC057	item			**2**	
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	
67	syringe 1ml	SC052	item	**1**			
68	cup, biopsy-specimen non-sterile 4oz	SL035	item	**1**			
69							
70	**EQUIPMENT**	**CODE**					
71	NO EQUIPMENT	EZ007		**0**	**0**		
72	light, exam	EQ168				**16**	**0**
73	table, exam	EF023				**16**	**0**

	A	B	C	D	E	F	G
1				REFERENCE CODE		Billed w-E/M	
2				20600 PEAC 2000		20600 Rev. 04/12	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)		Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**34**	**10**	**19**	**6**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**26**	**0**	**16**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8**	**10**	**3**	**0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**2**			
22	Obtain vital signs						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**0**	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**10**		**5**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
35	Complete diagnostic forms, lab & X-ray requisitions						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**	**6**
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**5**	**3**	**0**
53	Other Clinical Activity - *specify: Conduct phone calls/ lab stops completed and call lab*			**5**	**5**		
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	pack, minimum multi-specialty visit	SA048	pack	**0**			
57	drape, sterile barrier 16in x 29in	SB007	item	**1**		**1**	
58	gloves, sterile	SB024	pair	**1**		**1**	
59	povidone soln (Betadine)	SJ041	ml	**10**		**10**	
60	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**5**		**1**	
61	swab-pad, alcohol	SJ053	item			**2**	
62	needle, 18-27g	SC029	item	**2**		**4**	
63	syringe 3ml	SC055	item			**2**	
64	syringe 5-6ml	SC057	item				
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	
67	syringe 1ml	SC052	item	**1**			
68	cup, biopsy-specimen non-sterile 4oz	SL035	item	**1**			
69							
70	**EQUIPMENT**	**CODE**					
71	NO EQUIPMENT	EZ007		**0**	**0**		
72	light, exam	EQ168				**19**	**0**
73	table, exam	EF023				**19**	**0**

	A	B	C	H	I	J	K
1				REFERENCE CODE		Billed w-E/M	
2				20605 PEAC 2000		20605 Rev. 04/12	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular,		Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular,	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**34**	**10**	**19**	**6**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**26**	**0**	**16**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8**	**10**	**3**	**0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**2**			
22	Obtain vital signs						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**0**	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**10**		**5**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
35	Complete diagnostic forms, lab & X-ray requisitions						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**	**6**
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**5**	**3**	**0**
53	Other Clinical Activity - *specify: Conduct phone calls/ lab stops completed and call lab*			**5**	**5**		
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	pack, minimum multi-specialty visit	SA048	pack				
57	drape, sterile barrier 16in x 29in	SB007	item	**1**		**1**	
58	gloves, sterile	SB024	pair	**1**		**1**	
59	povidone soln (Betadine)	SJ041	ml	**10**		**10**	
60	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**5**		**3**	
61	swab-pad, alcohol	SJ053	item			**2**	
62	needle, 18-27g	SC029	item	**2**		**4**	
63	syringe 3ml	SC055	item			**2**	
64	syringe 5-6ml	SC057	item				
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	
67	syringe 1ml	SC052	item	**1**			
68	cup, biopsy-specimen non-sterile 4oz	SL035	item	**1**			
69							
70	**EQUIPMENT**	**CODE**					
71	NO EQUIPMENT	EZ007		**0**	**0**		
72	light, exam	EQ168				**19**	**0**
73	table, exam	EF023				**19**	**0**

	A	B	C	L	M	N	O
1				REFERENCE CODE		Billed w-E/M	
2				20610 PEAC 2000		20610 Rev. 04/12	
3	**Meeting Date: April 2012 Tab: Specialty: AAOS, ASSH**	**CMS Code**	**Staff Type**	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint,		Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint,	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**34**	**10**	**19**	**6**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**0**	**0**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**26**	**0**	**16**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8**	**10**	**3**	**0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**2**			
22	Obtain vital signs						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**0**	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**10**		**5**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
35	Complete diagnostic forms, lab & X-ray requisitions						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
38	Other Clinical Activity - *specify:*						
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**	**6**
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
42	**End: Patient leaves office**						
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**5**	**3**	**0**
53	Other Clinical Activity - *specify: Conduct phone calls/ lab stops completed and call lab*			**5**	**5**		
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
56	pack, minimum multi-specialty visit	SA048	pack				
57	drape, sterile barrier 16in x 29in	SB007	item	**1**		**1**	
58	gloves, sterile	SB024	pair	**1**		**1**	
59	povidone soln (Betadine)	SJ041	ml	**10**		**10**	
60	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**5**		**5**	
61	swab-pad, alcohol	SJ053	item			**2**	
62	needle, 18-27g	SC029	item	**2**		**4**	
63	syringe 3ml	SC055	item				
64	syringe 5-6ml	SC057	item			**2**	
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	**1**		**1**	
66	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	
67	syringe 1ml	SC052	item	**1**			
68	cup, biopsy-specimen non-sterile 4oz	SL035	item	**1**			
69							
70	**EQUIPMENT**	**CODE**					
71	NO EQUIPMENT	EZ007		**0**	**0**		
72	light, exam	EQ168				**19**	**0**
73	table, exam	EF023				**19**	**0**

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes screen

April 2012

Valve Replacement and CABG Procedures

In July 2011, these services were identified as part of the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC recommended that the specialty societies survey this service for work and practice expense. Rather than conduct a RUC survey the specialty society utilized data from the STS National Adult Cardiac Database, which meets the criteria established by the RUC for the use of extant data. It was also confirmed that the mean is the appropriate data point for analysis of the STS database. While the median is useful for analyzing smaller samples, the STS data has tens of thousands of data points and a mean is therefore more appropriate. The specialty society queried the years 2006-2010 to compare to data obtained from 2000-2004. The RUC reviewed the results of an intensity survey from 76 cardiac surgeons, whom indicated that the intensity of physician work has increased significantly since the codes were last reviewed in 2005 for the 3rd Five-Year Review. The RVU recommendations were calculated by multiplying the intensity measures and the service time, which is the same methodology that was used for valuation for the last review. The RUC did not employ the intensity survey submitted because its use in conjunction with extant data is not clearly permitted outside of the 5 year review under the current RUC policies and procedures.

CPT codes 33405 ***Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve***
The RUC reviewed the data from 78,332 patients and agreed with the specialty society that the work RVU of 41.32, the current value and below the computed value based on STS database time, appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialty society recommended physician time of 95 minutes pre-service, 197 minutes intra-service and 40 minutes post-service. The RUC agreed that pre-service time equivalent to a pre-service package 4 (difficult patient, difficult procedure), with additional time for evaluation and positioning of the patient, was appropriate for this service. The RUC agreed that an additional 20 minutes of evaluation time was appropriate to review the echocardiogram and angiogram, confirm the set up for the cardiopulmonary bypass and conduct a review of patient and planned procedure with qualified healthcare professionals involved in the service. An additional 12 minutes of positioning is also needed to adequately position the patient and position external equipment on the patient to ensure appropriate nerve protection and comfort. The STS data showed that the intra-service time remained relatively the same (198 to 197 minutes), and the intensity measures have increased. The specialty society indicated and the RUC agreed that the pre-service and post-service, as well as post-operative visits have not changed. The RUC reviewed reference codes with similar time and intensity and noted that CPT code 33031 *Pericardiectomy, subtotal or complete; with cardiopulmonary bypass* (work RVU=45.00) has similar intra-service time at 205 minutes and CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU=42.09), has similar intra-service time at 180 minutes and similar physician work. The RUC concurred that this service is valued appropriately and should maintain its value. **The RUC recommends a work RVU of 41.32 for CPT code 33405.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT code 33430 ***Replacement, mitral valve, with cardiopulmonary bypass***
The RUC reviewed the data set of 15,374 patients and agreed with the specialty society that the work RVU of 50.93, the current value and below the computed value based on STS database time, appropriately accounts for the physician work required to perform this service. The RUC agreed with specialty society recommended physician time of 95 minutes pre-service, 232 minutes intra-service and 40 minutes post-service. The RUC agreed that pre-service time equivalent to a pre-service package 4 (difficult patient, difficult procedure), with additional time for evaluation and positioning of the patient, was appropriate for this service. The RUC agreed that an additional 20 minutes of evaluation time was appropriate to review the echocardiogram and angiogram, confirm the set up for the cardiopulmonary bypass and conduct a review of patient and planned procedure with qualified healthcare professionals involved in the service. An additional 12 minutes of positioning is also needed to adequately position the patient and position external equipment on the patient to ensure appropriate nerve protection and comfort. The STS data showed that the intra-service time has increased from 223 to 232 minutes, and the intensity measures have increased. However, the specialty did not feel that a request for an increase could be justified at this time because the patients have not changed. The specialty society indicated and the RUC agreed that the pre-service and post-service, as well as post-operative visits have not changed. The RUC reviewed comparator codes with similar time and intensity and noted that CPT code 33465 *Replacement, tricuspid valve, with cardiopulmonary bypass* (work RVU=50.72) has similar physician time at 95 minutes pre-service, 211 minutes intra-service and 40 minutes post-service and CPT code 33875 *Descending thoracic aorta graft, with or without bypass* (work RVU=50.72), has similar intra-service time at 240 minutes and similar physician work. The RUC concurred that this service is valued appropriately and should maintain its value. **The RUC recommends a work RVU of 50.93 for CPT code 33430.**

CPT code 33533 ***Coronary artery bypass using arterial graft(s); single arterial graft***
The RUC agreed with the specialty society that there is compelling evidence to increase the value of this code based on an increase in intra-service time, a change in patient population and increased work intensity. Although the overall length of hospital stay was unchanged, there have been increases in the incidence of diabetes, heart failure, cerebrovascular disease and peripheral vascular disease. Most of the composite variables that predict increased morbidity have increased and the use of preoperative ADP blockers has increased. The patient population undergoing surgical myocardial revascularization has changed dramatically due to two factors. First, the drug eluting coronary stent was introduced in 2002-2003 and became prevalent at the very end of the 2000-2004 period used in establishing the current work values. This device has led to dramatic shifts in the surgical population towards patients having severe and diffuse coronary artery disease (and those with diabetes) toward percutaneous intervention. The second major change in the patient population is the prevalence of dual antiplatelet drug therapy that occurred in 2004 when the an FDA panel recommended at least 12 months of such therapy to minimize the occurrence of fatal drug eluting stent thrombosis. Increasing prevalence of dual antiplatelet therapy and the introduction of other agents such as direct thrombin inhibitors and irreversible fractionated heparin products have increased complexity and intensity of obtaining hemostasis during cardiac surgery. This has been compounded by the withdrawal of aprotinin from the marketplace in 2006. This was the only effective hemostatic agent in this anti-platelet drug environment, and was in widespread use during the 2000-2004 index time period.

The RUC reviewed the data set of 29,250 patients and agreed with the specialty recommended physician time of 95 minutes pre-service, 158

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minutes intra-service and 40 minutes post-service. The RUC agreed that pre-service time equivalent to a pre-service package 4 (difficult patient, difficult procedure), with additional time for evaluation and positioning of the patient, was appropriate for this service. The RUC agreed that an additional 20 minutes of evaluation time was appropriate to review the echocardiogram and angiogram, confirm the set up for the cardiopulmonary bypass and conduct a review of patient and planned procedure with qualified healthcare professionals involved in the service. An additional 12 minutes of positioning is also needed to adequately position the patient and position external equipment on the patient to ensure appropriate nerve protection and comfort. The STS data showed that the intra-service time has increased from 151 to 158 minutes, and the and the intensity measures have increased The specialty society indicated and the RUC agreed that the pre-service and post-service, as well as post-operative visits have not changed.

The RUC reviewed the results of an intensity survey from 76 cardiac surgeons, but did not employ the intensity survey submitted because its use in conjunction with extant data is not clearly permitted outside of the 5 year review under the current RUC policies and procedures. The RUC noted that this method should be further considered by the Research Subcommittee. The RUC used magnitude estimation and determined that a direct crosswalk to CPT code 33510 *Coronary artery bypass, vein only; single coronary venous graft* (work RVU = 34.98, intra-service time = 154 minutes), is appropriate. The RUC agreed with the specialty society that 33510 is less intense to perform than 33533, since an arterial graft is more complex than a vein graft. However, 33510 has one more post-operative visit than the surveyed code, thus validating the same value for these services. **The RUC recommends a work RVU of 34.98 for CPT code 33533, a direct crosswalk to CPT code 33510.**

Practice Expense

The RUC discussed that the staff type included in practice expense is an RN rather than the more common RN/LPN/MTA blend. The RUC agreed with the specialty society that during past reviews of cardiothoracic services, compelling evidence was accepted to justify the designation of RN as the clinical staff type. The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	090	41.32 (No Change)
33430	Replacement, mitral valve, with cardiopulmonary bypass	090	50.93 (No Change)
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	090	34.98

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33405 Tracking Number Specialty Society Recommended RVU: **41.32**
Global Period: 090 RUC Recommended RVU: **41.32**

CPT Descriptor: Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 67 year old male with aortic stenosis and one or more of the following risk factors for mortality or prolonged length of stay:

Diabetes requiring Insulin or oral agents	25%
Peripheral Vascular Disease	8%
Cerebral Vascular Disease	11%
Prior CVA	6%
Cardiogenic Shock	1%

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: o Perform Complete or Interval History and Physical Exam.
o Write pre-operative orders for peri-operative medications
o Review pre-operative work-up including relevant x-rays, cardiac catheterization and cardiac echocardiography
o Review any prior history and physical examination (if done)
o Review office notes from referring and primary physicians
o Review laboratory results (CBC, electrolytes, renal and liver function, coagulation)
o Review Cardiology and Pulmonary assessment as indicated
o Review the surgical procedure, post-op recovery in and out of the hospital, expected outcome(s) and any possible complications with patient and family
o Review choice of prosthetic valve (bioprosthetic vs mechanical) as well as anticoagulation implications associated with each valve choice with patient and family
o Obtain informed consent
o Identify patient, mark planned surgical incision site per policy
o Review planned procedure and positioning and draping of patient

o Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist with special attention to quality of ascending aorta and ventricular function
o Scrub, Gown and Glove
o Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas
o Perform "Time Out" so confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure

Description of Intra-Service Work: o A standard median sternotomy is made
o Inspect aorta for signs of atherosclerosis and determine cannulation site
o Give systemic heparin and place purse string sutures in aorta and right atrium
o Insert cannulas for cardiopulmonary bypass in the aorta and the right atrium
o Initiate cardiopulmonary bypass
o Place a left ventricular vent via the right superior pulmonary vein
o Place antegrade and retrograde cardioplegia cannulas
o Cross clamp the aorta and administer cardioplegia and topical hypothermia
o Open the ascending aorta
o Remove the native aortic valve
o Debride calcium from aortic annulus taking care to scavenge all debris to avoid particulate emboli
o Measure size of aortic annulus and select prosthesis
o Place sutures in aortic annulus and up through the sewing ring of the prosthetic valve
o Lower prosthesis into place and tie all sutures
o Confirm proper placement and function of prosthesis
o The aortotomy is closed
o Remove clamp with the patient in steep Trendelenberg position to minimize possibility of air or particulate matter embolus to the brain
o Ensure that aortic suture line is hemostatic
o Remove intra-cardiac air identified with intra operative trans esophageal echocardiography
o Place temporary atrial and ventricular pacing wires
o Separate patient from cardiopulmonary bypass
o Evaluate the post-procedure, intra-operative echocardiogram with specific attention to ventricular function, prosthesis function, and perivalvar leak
o When the patient is stable, administer protamine (to reverse heparin)and remove the arterial and venous perfusion cannulas.
o When hemostasis is adequate place mediastinal and, if necessary, pleural drains through separate small incisions
o Close median sternotomy incision

Description of Post-Service Work: Immediate Post-op same day work:
o Apply sterile dressings to the incision
o Remove drapes with close attention to pacing wires (if any), tubes and lines to ensure that none are dislodged or disconnected
o A detailed "hand-off" process is initiated by means of communication with the accepting physicians, nursing staff and other members of the health care team as to the nature of the operation and any complications or events that would require special attention
o Accompany patient to the ICU and direct the team should the patient's condition change en route
o Assure hemodynamic stabilization of the patient which includes review of the patients postoperative chest x-ray and EKG
o Write post operative orders
o Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any)
o Discuss procedure outcome with family and referring physician
Dictate post-op report
o Coordinate care with other physicians

Postoperative Critical Care

- Assess neurological state
- Monitor emergence from anesthesia
- Administer sedatives, paralyzing agents and analgesics as needed
- Evaluate gross neurologic function including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present
- Repeat evaluation until intraoperative neurologic injury is ruled out.
- Assess hemodynamic condition
- Evaluate cardiac rhythm
- Review 12-lead EKG for signs or ischemia or injury, compare to preoperative tracing
- Assess blood pressure, central venous pressure, pulmonary artery pressures, cardiac output and index
- Administer crystalloid fluids or blood products depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures
- Adjust inotropic and vasoactive agents given by continuous infusion to optimize O2 delivery and minimize adverse end-organ effects
- Carefully evaluate peripheral perfusion by observation and physical exam, correlating findings with invasive monitoring results
- Monitor chest tube bleeding
- Presence of tamponade state is assessed.
- Assess laboratory results, correlate with other findings, and determine the need for blood, blood products including platelets cryoprecipitate and fresh frozen plasma
- Examine breath sounds, observe chest mechanics, assure mid-line tracheal position by physical exam
- Assess ventilator settings, observe underlying respiratory pattern, observe baseline airway pressures generated and minute gas flow
- Confirm endo-tracheal tube placement by review of post-operative chest x-ray
- Monitor lungs for infiltrate/atalectasis
- Assess pleural spaces for fluid collection
- Assess blood gases and adjust ventilator as needed
- Assess for possibility and timing of weaning from ventilator
- Assess adequacy of urine output
- Assess volume status and administer fluids or diuretics as needed
- Monitor distal extremity perfusion
- Discuss interval plans with nursing staff
- Set parameters for interval adjustments in patient treatment
- Chart patient progress notes

Remainder of Post-op hospital work

- Continue to monitor patient's hemodynamic status .
- Inspect all wounds daily for drainage, underlying hematoma, or inflammation
- Assess postoperative pain, use of analgesics, adequacy of response
- Assess character of pulmonary secretions, patients ability to clear airway
- Review vital signs, I&O, laboratory results, patient daily weight
- Review chest radiograph
- Evaluate cardiac monitor for rate, rhythm, presence or absence of arrhythmia
- Assess progress of system recovery, assess risk for development of complications
- Encourage ambulation and vigorous pulmonary physiotherapy
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral (if necessary) and oral feedings
- Remove chest tube when appropriate (usually 24-48 hours post-operatively)
- Answer patient/family questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- If indicated, implement systemic anticoagulation at earlier possible opportunity with heparin and subsequent warfarin therapy
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Document evaluation, patient progress and plan in medical record
- At discharge, carefully explain to patient and a family member dietary management, activities permitted, bathing, return appointment to office, etc.
- Coordinate care with other physicians

- Answer patient/family questions
- Write prescriptions and discharge instructions
- Explain nature, purpose and expected duration of use of new medications. Detailed instructions on warfarin therapy and drug as well as food interactions. If needed, arrange and explain the need for frequent lab testing until the warfarin dose is stabilized. Specific instructions on the need to notify other treating physicians or dentists of the presence of a heart valve abnormality and the need for prophylactic peri-procedural antibiotics. Review patients home medications
- Dictate discharge summary
- Communicate with patient's primary care physician(s)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD		
Specialty(s):	cardiothoracic surgery		
CPT Code:	33405		
Sample Size:	78332	**Resp N:** 0	**Response:** 0.0 %
Sample Type:	**Additional Sample Information:** based on 2006 - 2010 STS database data		

	Low	25th %	Median*	75th %	High
Service Performance Rate					
Survey RVW:			**42.58**		
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:			**197.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**265.00**	99231x **1.00** 99232x **2.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**63.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33405	**Recommended Physician Work RVU: 41.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**60.00**	**40.00**	**20.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**197.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**265.00**	99231x **1.00** 99232x **2.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**63.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33405	090	41.32	**RUC Time**

CPT Descriptor Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

Inputs provided for Reference code represent the existing data for the code in the RUC database based on 2000-2004 STS database data

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
CPT Descriptor 1				
MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
CPT Descriptor 2				

Other Reference CPT Code	Global	Work RVU	Time Source
CPT Descriptor			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33405**	**Key Reference CPT Code:** 33405	**Source of Time** **RUC Time**
Median Pre-Service Time	95.00	95.00	
Median Intra-Service Time	197.00	198.00	
Median Immediate Post-service Time	40.00	40.00	
Median Critical Care Time	70.0	70.00	
Median Other Hospital Visit Time	265.0	265.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	63.0	63.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**768.00**	**769.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In response to a request by CMS to the RUC, the STS National Adult Cardiac Database was queried for the years 2006-2010 to compare to data obtained from 2000-2004 to support the current valuation. The data set included 78,332 patients and met the criteria established for database utilization by the RUC. An analysis of annual procedural

performance as captured in the database, compared to Medicare Utilization files indicates that more than 95% of performed cardiac procedures are now included.

Data extraction and reporting are identical to that performed during the 2005 5-year review. Briefly, only those records that could be unequivocally and exclusively matched to this CPT code were utilized. Patients were excluded if other cardiac procedures were performed simultaneously, if the patient had prior CABG or prior Valve replacement, or if they returned to the operative room for another procedure during the index hospitalization. Length of hospital stay was truncated to 90 days if greater than 90 days.

Additional pre-service time has been recommended for evaluation and positioning of patient. For pre-service evaluation 10 minutes have been added for review echocardiogram and angiogram, as well as real time review of transesophageal echo performed prior to prep to confirm diagnosis, annular size and availability of appropriate sized valve prosthesis. 3 minutes has been added to confirm set up for cardiopulmonary bypass, availability of blood, availability of perfusionists. 7 minutes has been added to perform briefing and time out (2 separable events) with anesthesiology, nursing, perfusion, physician assistant anesthesia technician and other support staff with complete review of patient and planned procedure. For pre-service positioning of patient, 12 minutes has been added to place external defibrillator pads in correct position to effect defibrillation and not interfere with planned or potential incisions. Place roll midline upper thoracic to enable sternal separation, or beanbag position for thoractomy approach with right chest rotated 45 degrees to hip plane. Ensure patient has bilateral ulna nerve protection and carefully secure patient arms at his side. Confirm appropriate fixed, ophthalmologic protection prior to deployment of sterile drapes and any retraction aid devices. Position and confirm reliable signals from additional EKG electrodes to syncrhonize intra-aortic balloon pump (all cases, preparation for potential need to separate from cardiopulmonary bypass). Postion legs in frogleg after circumferential prep, ensure protection of lateral fibular condyle to prevent peroneal nerve injury.

An intensity survey was performed to evaluate this element of physician work, and the reference service list is submitted as an exhibit. The survey was sent to a random sample of cardiac surgeons, with 76 respondents. Respondents also answered the 5-year review questions. The survey indicated that physician work has increased significantly since its last valuation, and that the intraservice work has increased from 0.105 to 0.112 per unit time.

The STS data showed that the intraservice time has decreased from 198 to 197 minutes. The overall length of hospital stay was unchanged as was the ventilator time. The patients were 1.7 years older, and more had diabetes. Overall, the prevalence of comorbid features, complications and overall demographics are presented in comparison to the data from 2000-2004 in a handout. The building block method employed in the 2005 5-year review was utilized with new inputs for intraservice time, intraservice work per unit time and unchanged time and visit inputs. This resulted in a work value of **42.58** which is an increase compared to the current value of 41.32. The building block is included as a separate document.

The expert panel reviewed the data, and recommends that the current value of **41.32** be retained along with the current time and visit inputs. It is likely that the patient population will change significantly in the near future with the introduction of effective transcatheter alternatives to surgical aortic valve replacement, and may warrant reintroduction into the rolling review process.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) Yes

If no, please select another crosswalk and provide a brief rationale. 33405

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

N/A

Five-Year Review Specific Questions

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%).

Has the work of performing this service changed in the past 5 years? Yes 78% No 22%

A. This service represents new technology? Yes 53% No 26%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 3% Same Work: 4% More Work: 54%

B. This service reflects new technology that has become more familiar: Yes 37% No 37%

C. Patients requiring this service are now:

More complex (more work) 71% Less complex (less work) 0% No change in complexity 8%

D. The typical site-of-service has changed:

From outpatient to inpatient 5% From inpatient to outpatient 0% No change 72%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33430 Tracking Number Specialty Society Recommended RVU: **50.93**
Global Period: 090 RUC Recommended RVU: **50.93**

CPT Descriptor: Replacement, mitral valve, with cardiopulmonary bypass

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 61 year old female with mitral valve disease and one or more of the following risk factors for mortality or prolonged length of stay:

Diabetes requiring Insulin or oral agents	19%
Peripheral Vascular Disease	6%
Cerebral Vascular Disease	15%
Prior CVA	11%
Cardiogenic Shock	3%

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work: o Perform Complete or Interval History and Physical Exam.
o Write pre-operative orders for peri-operative medications
o Review pre-operative work-up including relevant x-rays, cardiac catheterization and cardiac echocardiography
o Review any prior history and physical examination (if done)
o Review office notes from referring and primary physicians
o Review laboratory results (CBC, electrolytes, renal and liver function, coagulation)
o Review Cardiology and pulmonary assessment as indicated
o Review the surgical procedure, post-op recovery in and out of the hospital, expected outcome(s) and any possible complications with patient and family
o Review choice of prosthetic valve (bioprosthetic vs mechanical) as well as anticoagulation implications associated with each valve choice with patient and family
o Obtain informed consent
o Identify patient, mark planned surgical incision site per policy
o Review planned procedure and positioning and draping of patient
o Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist with special attention to quality of ascending aorta and ventricular function

o Scrub, Gown and Glove
o Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas
o Perform "Time Out" so confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure

Description of Intra-Service Work: o A standard median sternotomy is made
o Inspect aorta for signs of atherosclerosis and determine cannulation site
o Give systemic heparin and place purse string sutures in aorta and right atrium
o Insert cannulas for cardiopulmonary bypass in the aorta and the Superior and Inferior Vena Cavae for bicaval venous drainage
o Initiate cardiopulmonary bypass
o Check with anesthesiologist and/or perfusionist regarding activated clotting time to assess level of heparinization
o Dissect the inter-atrial plane
o Initiate systemic cooling
o Cross clamp the aorta and administer cardioplegia and topical hypothermia
o Open the left atrium
o Remove any intra-atrial thrombus
o Oversew the left atrial appendage
o Inspect and analyze pathology of the mitral valve
o Perform partial valve resection preserving posterior leaflet and as much of the anterior leaflet as possible
o Use sizer to determine appropriate sized prosthesis
o Place pledgeted mattress sutures in the mitral annulus and up through the sewing ring of valve
o Seat valve, verify no suture entrapment on valve struts, tie and cut all sutures
o Verify free motion of valve leaflets, especially with mechanical prostheses
o Close left atrium with two layers of suture
o Place patient in steep Trendelenberg position and remove aortic cross clamp taking care to avoid cerebral air embolus
o Remove intra-cardiac air monitoring with echocardiography
o Place temporary pacing wires and begin atrial, atrio-ventricular, or ventricular pacing if indicated
o Discontinue cardiopulmonary bypass, monitoring hemodynamics with arterial and pulmonary artery lines
o Evaluate the post-procedure, intra-operative echocardiogram specifically examining for ventricular function, prosthesis function, and perivalvar leak
o When the patient is stable, give protamine and remove the arterial and venous cannulas.
o When hemostasis is adequate place pericardial and, if necessary, pleural drains
o Close the median sternotomy wound.

Description of Post-Service Work: Immediate Post-op same day work:
o Apply sterile dressings to the incision
o Remove drapes with close attention to pacing wires (if any), tubes and lines to ensure that none are dislodged or disconnected
o A detailed "hand-off" process is initiated by means of communication with the accepting physicians, nursing staff and other members of the health care team as to the nature of the operation and any complications or events that would require special attention
o Accompany patient to the ICU and direct the team should the patient's condition change en route
o Assure hemodynamic stabilization of the patient which includes review of the patients postoperative chest x-ray and EKG
o Write post operative orders
o Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any)
o Discuss procedure outcome with family and referring physician
Dictate post-op report
o Coordinate care with other physicians

Postoperative Critical Care

- Assess neurological state
- Monitor emergence from anesthesia
- Administer sedatives, paralyzing agents and analgesics as needed
- Evaluate gross neurologic function including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present
- Repeat evaluation until intraoperative neurologic injury is ruled out.
- Assess hemodynamic condition
- Evaluate cardiac rhythm
- Review 12-lead EKG for signs or ischemia or injury, compare to preoperative tracing
- Assess blood pressure, central venous pressure, pulmonary artery pressures, cardiac output and index
- Administer crystalloid fluids or blood products depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures
- Adjust inotropic and vasoactive agents given by continuous infusion to optimize O2 delivery and minimize adverse end-organ effects
- Carefully evaluate peripheral perfusion by observation and physical exam, correlating findings with invasive monitoring results
- Monitor chest tube bleeding
- Presence of tamponade state is assessed.
- Assess laboratory results, correlate with other findings, and determine the need for blood, blood products including platelets cryoprecipitate and fresh frozen plasma
- Examine breath sounds, observe chest mechanics, assure mid-line tracheal position by physical exam
- Assess ventilator settings, observe underlying respiratory pattern, observe baseline airway pressures generated and minute gas flow
- Confirm endo-tracheal tube placement by review of post-operative chest x-ray
- Monitor lungs for infiltrate/atalectasis
- Assess pleural spaces for fluid collection
- Assess blood gases and adjust ventilator as needed
- Assess for possibility and timing of weaning from ventilator
- Assess adequacy of urine output
- Monitor distal extremity perfusion
- Discuss interval plans with nursing staff
- Set parameters for interval adjustments in patient treatment
- Chart patient progress notes

Remainder of Post-op hospital work

- Continue to monitor patient's hemodynamic status .
- Inspect all wounds daily for drainage, underlying hematoma, or inflammation
- Assess postoperative pain, use of analgesics, adequacy of response
- Assess character of pulmonary secretions, patients ability to clear airway
- Review vital signs, I&O, laboratory results, patient daily weight
- Review chest radiograph
- Evaluate cardiac monitor for rate, rhythm, presence or absence of arrhythmia
- Encourage ambulation and vigorous pulmonary physiotherapy
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral (if necessary) and oral feedings
- Remove chest tube when appropriate (usually 24-48 hours post-operatively)
- Answer patient/family questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- If indicated, implement systemic anticoagulation at earlier possible opportunity with heparin and subsequent warfarin therapy
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Document evaluation, patient progress and plan in medical record
- At discharge, carefully explain to patient and a family member dietary management, activities permitted, bathing, return appointment to office, etc.
- Coordinate care with other physicians
- Write prescriptions and discharge instructions

- Explain nature, purpose and expected duration of use of new medications. Detailed instructions on warfarin therapy and drug as well as food interactions. If needed, arrange and explain the need for frequent lab testing until the warfarin dose is stabilized. Specific instructions on the need to notify other treating physicians or dentists of the presence of a heart valve abnormality and the need for prophylactic peri-procedural antibiotics. Review patients home medications
- Dictate discharge summary
- Communicate with patient's primary care physician(s)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD		
Specialty(s):	cardiothoracic surgery		
CPT Code:	33430		
Sample Size: 15374	**Resp N:** 0	**Response:** 0.0 %	
Sample Type:	**Additional Sample Information:** based on 2006 - 2010 STS database data		

	Low	25th %	Median*	75th %	High
Service Performance Rate					
Survey RVW:			**52.59**		
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:			**232.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**140.00**	99291x **2.00** 99292x **0.00**
Other Hospital time/visit(s):	**265.00**	99231x **1.00** 99232x **2.00** 99233x **3.00**
Discharge Day Mgmt:	**55.00**	99238x **0.00** 99239x **1.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33430	**Recommended Physician Work RVU: 50.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**60.00**	**40.00**	**20.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**232.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**140.00**	99291x **2.00** 99292x **0.00**
Other Hospital time/visit(s):	**265.00**	99231x **1.00** 99232x **2.00** 99233x **3.00**
Discharge Day Mgmt:	**55.00**	99238x **0.0** 99239x **1.0**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33430	090	50.93	**RUC Time**

CPT Descriptor Replacement, mitral valve, with cardiopulmonary bypass
Inputs provided for Reference code represent the existing data for the code in the RUC database based on 2000-2004 STS database data

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
CPT Descriptor 1				
MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
CPT Descriptor 2				

Other Reference CPT Code	Global	Work RVU	Time Source
CPT Descriptor			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33430**	**Key Reference CPT Code:** 33430	**Source of Time** **RUC Time**
Median Pre-Service Time	95.00	95.00	
Median Intra-Service Time	232.00	223.00	
Median Immediate Post-service Time	40.00	40.00	
Median Critical Care Time	140.0	140.00	
Median Other Hospital Visit Time	265.0	265.00	
Median Discharge Day Management Time	55.0	55.00	
Median Office Visit Time	86.0	86.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**913.00**	**904.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In response to a request by CMS to the RUC, the STS National Adult Cardiac Database was queried for the years 2006-2010 to compare to data obtained from 2000-2004 to support the current valuation. The data set included 15,374 patients and met the criteria established for database utilization by the RUC. An analysis of annual procedural

performance as captured in the database, compared to Medicare Utilization files indicates that more than 95% of performed cardiac procedures are now included.

Data extraction and reporting are identical to that performed during the 2005 5-year review. Briefly, only those records that could be unequivocally and exclusively matched to this CPT code were utilized. Patients were excluded if other cardiac procedures were performed simultaneously, if the patient had prior CABG or prior Valve replacement, or if they returned to the operative room for another procedure during the index hospitalization. Length of hospital stay was truncated to 90 days if greater than 90 days.

Additional pre-service time has been recommended for evaluation and positioning of patient. For pre-service evaluation 10 minutes have been added for review echocardiogram and angiogram, as well as real time review of transesophageal echo performed prior to prep to confirm diagnosis, annular size and availability of appropriate sized valve prosthesis. 3 minutes has been added to confirm set up for cardiopulmonary bypass, availability of blood, availability of perfusionists. 7 minutes has been added to perform briefing and time out (2 separable events) with anesthesiology, nursing, perfusion, physician assistant anesthesia technician and other support staff with complete review of patient and planned procedure. For pre-service positioning of patient, 12 minutes has been added to place external defibrillator pads in correct position to effect defibrillation and not interfere with planned or potential incisions. Place roll midline upper thoracic to enable sternal separation, or beanbag position for thoractomy approach with right chest rotated 45 degrees to hip plane. Ensure patient has bilateral ulna nerve protection and carefully secure patient arms at his side. Confirm appropriate fixed, ophthalmologic protection prior to deployment of sterile drapes and any retraction aid devices. Position and confirm reliable signals from additional EKG electrodes to syncrhonize intra-aortic balloon pump (all cases, preparation for potential need to separate from cardiopulmonary bypass). Postion legs in frogleg after circumferential prep, ensure protection of lateral fibular condyle to prevent peroneal nerve injury.

An intensity survey was performed to evaluate this element of physician work, and the reference service list is submitted as an exhibit. The survey was sent to a random sample of cardiac surgeons, with 76 respondents. Respondents also answered the 5-year review questions. The survey indicated that physician work has increased significantly since its last valuation, and that the intraservice work has increased from 0.109 to 0.112 per unit time.

The STS data showed that the intraservice time has increased from 223 to 232 minutes. The overall length of hospital stay was unchanged as was the ventilator time. The patients were 0.2 years younger, and more had diabetes and cerebrovascular disease. Overall, the prevalence of comorbid features, complications and overall demographics are presented in comparison to the data from 2000-2004 in a handout. The building block method employed in the 2005 5-year review was utilized with new inputs for intraservice time, intraservice work per unit time and unchanged time and visit inputs. This resulted in a work value of **52.59** which is an increase compared to the current value of 50.93. The building block is included as a separate document.

The expert panel reviewed the data, and recommends that the current value of **50.93** be retained along with the current time and visit inputs. It is not likely that the patient population will change significantly in the near future as transcatheter treatments have not been effective.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) Yes

If no, please select another crosswalk and provide a brief rationale. 33430

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

N/A

Five-Year Review Specific Questions

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%).

Has the work of performing this service changed in the past 5 years? Yes 82% No 18%

A. This service represents new technology? Yes 50% No 32%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 1% Same Work: 3% More Work: 55%

B. This service reflects new technology that has become more familiar: Yes 42% No 30%

C. Patients requiring this service are now:

More complex (more work) 70% Less complex (less work) 0% No change in complexity 12%

D. The typical site-of-service has changed:

From outpatient to inpatient 4% From inpatient to outpatient 0% No change 75%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33533 Tracking Number Specialty Society Recommended RVU: **35.39**
Global Period: 090 RUC Recommended RVU: **34.98**

CPT Descriptor: Coronary artery bypass, using arterial graft(s); single arterial graft

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 62 year old male with significant coronary artery disease and one or more of the following risk factors for mortality or prolonged length of stay:

Diabetes requiring Insulin or oral agents	33%
Peripheral Vascular Disease	13%
Cerebral Vascular Disease	12%
Prior CVA	6%
Cardiogenic Shock	1%

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work: o Perform Complete or Interval History and Physical Exam.
o Write pre-operative orders for peri-operative medications
o Review pre-operative work-up including relevant x-rays, cardiac catheterization and cardiac echocardiography
o Review any prior history and physical examination (if done)
o Review office notes from referring and primary physicians
o Review laboratory results (CBC, electrolytes, renal and liver function, coagulation)
o Review Cardiology and pulmonary assessment as indicated
o Review the surgical procedure, post-op recovery in and out of the hospital, expected outcome(s) and any possible complications with patient and family
o Obtain informed consent
o Identify patient, mark planned surgical incision site per policy
o Review planned procedure and positioning and draping of patient
o Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist with special attention to quality of ascending aorta and ventricular function
o Scrub, Gown and Glove

o Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas
o Prep and drape arm if radial artery graft planned
o Perform "Time Out" so confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure

Description of Intra-Service Work: o A standard median sternotomy incision is made
o Dissect Left Internal Mammary Artery using electrocautery and apply clips to vessel branches on LIMA
o Administer systemic heparin
o Assess chest wall for bleeding and cauterize as necessary
o Incise pericardium
o Inspect aorta for signs of atherosclerosis and determine cannulation site
o Determine appropriate cannulas to use based on anatomy and patient BSA
o Place purse string sutures in aorta and right atrium
o Check with anesthesiologist and/or perfusionist regarding activated clotting time value to assess level of heparinization
o Insert cannulas for cardiopulmonary bypass in the aorta and the right atrium
o Initiate cardiopulmonary bypass
o Place antegrade and retrograde (if necessary) cardioplegia cannulas if cardiac arrest planned
o Cross clamp the aorta and administer cardioplegia and topical hypothermia
o Perform coronary arteriotomy
o Perform end-to-side LIMA anastomosis to target coronary vessel using fine monofilament suture and optical magnification
o Remove cross-clamp taking care to avoid cerebral air embolus
o Place temporary pacing wires and begin atrial, atrio-ventricular, or ventricular pacing if indicated
o Discontinue cardiopulmonary bypass
o Evaluate the post-procedure, intra-operative echocardiogram specifically examining for ventricular function and regional wall motion abnormalities
o When the patient is stable, administer protamine (to reverse heparin) and remove the arterial and venous cannulas.

o When hemostasis is adequate place pericardial and, if necessary, pleural drains through separate small incisions
o The median sternotomy is closed

Description of Post-Service Work: Immediate Post-op same day work:
o Apply sterile dressings to the incision
o Remove drapes with close attention to pacing wires (if any), tubes and lines to ensure that none are dislodged or disconnected
o A detailed "hand-off" process is initiated by means of communication with the accepting physicians, nursing staff and other members of the health care team as to the nature of the operation and any complications or events that would require special attention
o Accompany patient to the ICU and direct the team should the patient's condition change en route
o Assure hemodynamic stabilization of the patient which includes review of the patients postoperative chest x-ray and EKG
o Write post operative orders
o Write brief operative note for the patient's chart documenting in the daily progress notes pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any)
o Discuss procedure outcome with family and referring physician
Dictate post-op report
o Coordinate care with other physicians

Postoperative Critical Care

o Assess neurological state
o Monitor emergence from anesthesia
o Administer sedatives, paralyzing agents and analgesics as needed

- Evaluate gross neurologic function including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present
- Repeat evaluation until intraoperative neurologic injury is ruled out.
- Assess hemodynamic condition
- Evaluate cardiac rhythm
- Review 12-lead EKG for signs or ischemia or injury, compare to preoperative tracing
- Assess blood pressure, central venous pressure, pulmonary artery pressures, cardiac output and index
- Administer crystalloid fluids or blood products depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures
- Adjust inotropic and vasoactive agents given by continuous infusion to optimize O2 delivery and minimize adverse end-organ effects
- Carefully evaluate peripheral perfusion by observation and physical exam, correlating findings with invasive monitoring results
- Monitor chest tube bleeding
- Presence of tamponade state is assessed.
- Assess laboratory results, correlate with other findings, and determine the need for blood, blood products including platelets cryoprecipitate and fresh frozen plasma
- Examine breath sounds, observe chest mechanics, assure mid-line tracheal position by physical exam
- Assess ventilator settings, observe underlying respiratory pattern, observe baseline airway pressures generated and minute gas flow
- Confirm endo-tracheal tube placement by review of post-operative chest x-ray
- Monitor lungs for infiltrate/atalectasis
- Assess pleural spaces for fluid collection
- Assess blood gases and adjust ventilator as needed
- Assess for possibility and timing of weaning from ventilator
- Assess adequacy of urine output
- Monitor distal extremity perfusion
- Discuss interval plans with nursing staff
- Set parameters for interval adjustments in patient treatment
- Chart patient progress notes

Remainder of Post-op hospital work

- Continue to monitor patient's hemodynamic status .
- Inspect all wounds daily for drainage, underlying hematoma, or inflammation
- Assess postoperative pain, use of analgesics, adequacy of response
- Assess character of pulmonary secretions, patients ability to clear airway
- Review vital signs, I&O, laboratory results, patient daily weight
- Review chest radiograph
- Evaluate cardiac monitor for rate, rhythm, presence or absence of arrhythmia
- Encourage ambulation and vigorous pulmonary physiotherapy
- Carefully assess and monitor postoperative nutritional status as maintained by both enteral (if necessary) and oral feedings
- Remove chest tube when appropriate (usually 24-48 hours post-operatively)
- Answer patient/family questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Document evaluation, patient progress and plan in medical record
- At discharge, carefully explain to patient and a family member dietary management, activities permitted, bathing, return appointment to office, etc.
- Coordinate care with other physicians
- Write prescriptions and discharge instructions
- Explain nature, purpose and expected duration of use of new medications. Detailed instructions on warfarin therapy and drug as well as food interactions. If needed, arrange and explain the need for frequent lab testing until the warfarin dose is stabilized. Specific instructions on the need to notify other treating physicians or dentists of the presence of a heart valve abnormality and the need for prophylactic peri-procedural antibiotics. Review patients home medications
- Dictate discharge summary
- Communicate with patient's primary care physician(s

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD		
Specialty(s):	cardiothoracic surgery		
CPT Code:	33533		
Sample Size:	29250	**Resp N:** 0	**Response:** 0.0 %
Sample Type:	**Additional Sample Information:** based on 2006 - 2010 STS database data		

	Low	25th %	Median*	75th %	High
Service Performance Rate					
Survey RVW:			**35.39**		
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:			**158.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**225.00**	99231x **1.00** 99232x **1.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**56.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33533	**Recommended Physician Work RVU: 35.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**60.00**	**40.00**	**20.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**158.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**225.00**	99231x **1.00** 99232x **1.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**56.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33533	090	33.75	**RUC Time**

CPT Descriptor Coronary artery bypass, using arterial graft(s); single arterial graft
Inputs provided for Reference code represent the existing data for the code in the RUC database based on 2000-2004 STS database data

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33533**	**Key Reference CPT Code:** 33533	**Source of Time RUC Time**
Median Pre-Service Time	95.00	95.00	
Median Intra-Service Time	158.00	151.00	
Median Immediate Post-service Time	40.00	40.00	
Median Critical Care Time	70.0	70.00	
Median Other Hospital Visit Time	225.0	225.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	56.0	56.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**682.00**	**675.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In response to a request by CMS to the RUC, the STS National Adult Cardiac Database was queried for the years 2006-2010 to compare to data obtained from 2000-2004 to support the current valuation. The data set included 29,250 patients and met the criteria established for database utilization by the RUC. An analysis of annual procedural

performance as captured in the database, compared to Medicare Utilization files indicates that more than 95% of performed cardiac procedures are now included.

Data extraction and reporting are identical to that performed during the 2005 5-year review. Briefly, only those records that could be unequivocally and exclusively matched to this CPT code were utilized. Patients were excluded if other cardiac procedures were performed simultaneously, if the patient had prior CABG or prior Valve replacement, or if they returned to the operative room for another procedure during the index hospitalization. Length of hospital stay was truncated to 90 days if greater than 90 days.

Additional pre-service time has been recommended for evaluation and positioning of patient. For pre-service evaluation 10 minutes have been added for review echocardiogram and angiogram, as well as real time review of transesophageal echo performed prior to prep to confirm diagnosis, rule out inter-atrial communication and valvular heart disease, and to ensure that no new wall motion abnormalites or reduction in ventriclar function has occured since preoperative studies were obtained. 3 minutes has been added to confirm set up for cardiopulmonary bypass, availability of blood, availability of perfusionists. 7 minutes has been added to perform briefing and time out (2 separable events) with anesthesiology, nursing, perfusion, physician assistant anesthesia technician and other support staff with complete review of patient and planned procedure. For pre-service positioning of patient, 12 minutes has been added to place external defibrillator pads in correct position to effect defibrillation and not interfere with planned or potential incisions. Place roll midline upper thoracic to enable sternal separation, or beanbag position for thoractomy approach with right chest rotated 45 degrees to hip plane. Ensure patient has bilateral ulna nerve protection and carefully secure patient arms at his side. Confirm appropriate fixed, ophthalmologic protection prior to deployment of sterile drapes and any retraction aid devices. Position and confirm reliable signals from additional EKG electrodes to syncrhonize intra-aortic balloon pump (all cases, preparation for potential need to separate from cardiopulmonary bypass). Postion legs in frogleg after circumferential prep, ensure protection of lateral fibular condyle to prevent peroneal nerve injury.

An intensity survey was performed to evaluate this element of physician work, and the reference service list is submitted as an exhibit. The survey was sent to a random sample of cardiac surgeons, with 76 respondents. Respondents also answered the 5-year review questions. The survey indicated that physician work has increased significantly since its last valuation, and that the intraservice work has increased from 0.100 to 0.106 per unit time.

The STS data showed that the intraservice time has increased from 151 to 158 minutes, and there were increases in many of the indicators of critical illness. The overall length of hospital stay was unchanged. The prevalence of comorbid features, complications and overall demographics are presented in comparison to the data from 2000-2004 in a handout. The average patient age has decreased by 0.4 years. There have been increases in the incidence of diabetes, heart failure, cerebrovascular disease and peripheral vascular disease. Most of the composite variables that predict increased morbidity have increased. The use of preoperative ADP blockers, which include clopidogrel and prasugrel has increased from 13% to 17%. This was associated with a definitional change from at any time prior to surgery to within 5 days of surgery, a further indicator of increased antiplatelet agent activity at the time of surgery. An expert panel reviewed the data and recommended no change in the number or level of postoperative visits from those already determined in 2005 based upon these data elements.

The building block method employed in the 2005 5-year review was utilized with new inputs for intraservice time, intraservice work per unit time and unchanged time and visit inputs. This resulted in a work value of **35.39** which is an increase compared to the current value of 33.75. The building block is included as a separate document.

We believe that compelling evidence is present to justify this recommended new work value.

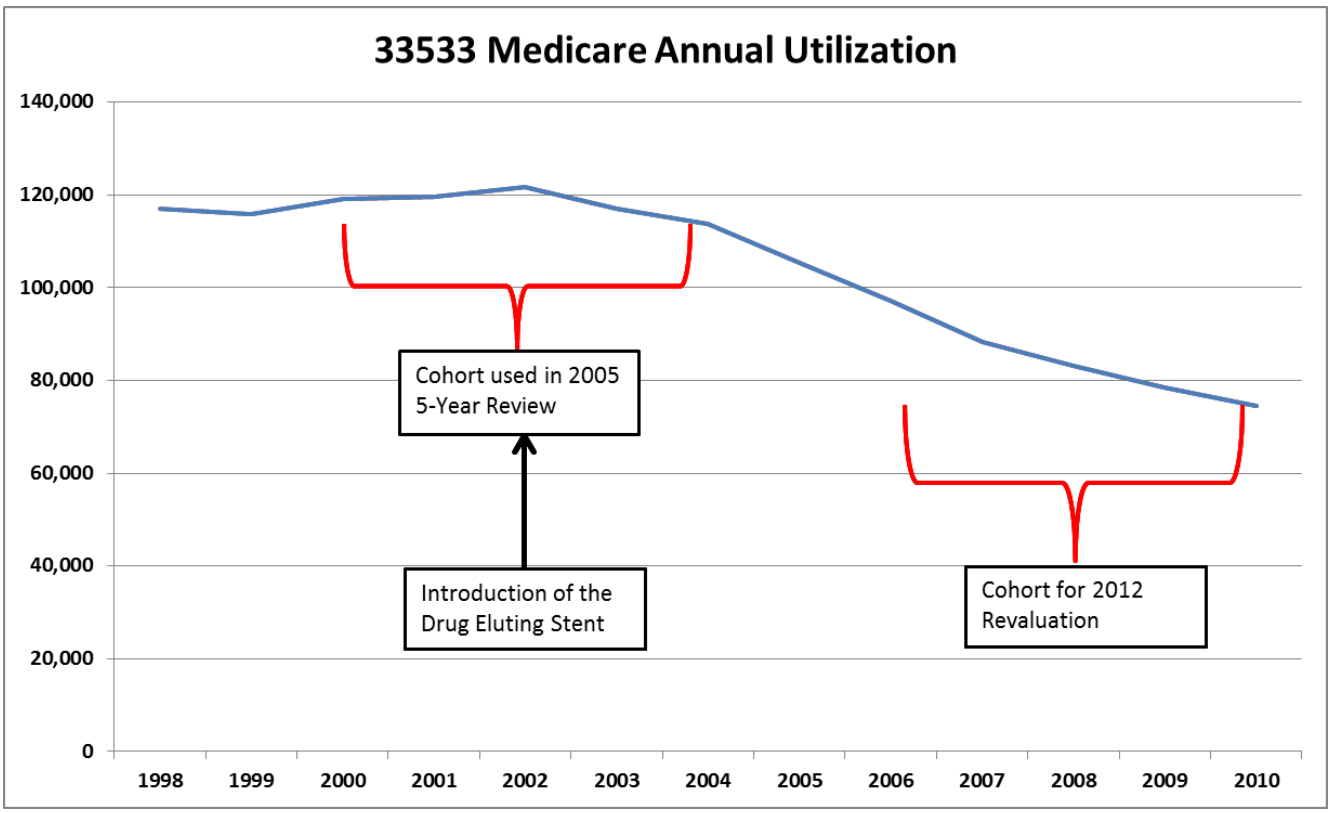
The first element of compelling evidence is the indisputable increase in measured intraservice time.

The second element of compelling evidence is the change in patient population to one with more comorbidity and more surgical risk.

The third element of compelling evidence is the survey respondent's assessment of the patient population and work intensity.

The patient population undergoing surgical myocardial revascularization has changed dramatically due to two factors.

First, the drug eluting coronary stent was introduced in 2002-3 and became prevalent at the very end of the 2000-2004 period used in establishing the current work values. This device has led to dramatic shifts in the patient population toward percutaneous intervention as in the following graph:



This shift of patients from surgery to percutaneous intervention has not been uniform, but has rather enriched the surgical population with patients having severe and diffuse coronary artery disease (and those with diabetes). There have been multiple publications from randomized clinical trials and registries that indicate that PCI is being performed in patients who previously would have had surgery, but whose coronary anatomy is less complex and diffuse and thus more amenable to stenting. These factors have been recently embodied in revisions to the CABG/PCI guidelines and the ACCF/AHA Appropriateness Criteria for Revascularization. To a significant extent, these recommendations have been responsive to cardiology practice rather than directive. The impact of these changing patterns has been to increase the severity of distal coronary disease and to present the surgeon with smaller diameter and more diseased coronary "targets" for anastomosis.

The second major change in the patient population is the prevalence of dual antiplatelet drug therapy that occurred in 2004 when the an FDA panel recommended at least 12 months of such therapy to minimize the occurrence of fatal drug eluting stent thrombosis. This has become essentially indefinite therapy in patient who can tolerate it. In addition, patients are being "loaded" with these agents prior to diagnostic cardiac catheterization in anticipation of percutaneous intervention, only to be found to require referral for coronary bypass grafting. The increasing prevalence of dual antiplatelet therapy and the introduction of other agents such as direct thrombin inhibitors and irreversible fractionated heparin products have increased complexity and intensity of obtaining hemostasis during cardiac surgery.

This has been compounded by the withdrawal of aprotinin from the marketplace in 2006. This was the only effective hemostatic agent in this anti-platelet drug environment, and was in widespread use during the 2000-2004 index time period.

References are included with this application in support.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) Yes

If no, please select another crosswalk and provide a brief rationale. 33533

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).
See rationale above

Five-Year Review Specific Questions

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%).

Has the work of performing this service changed in the past 5 years? Yes 70% No 30%

A. This service represents new technology? Yes 33% No 43%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 0% Same Work: 70% More Work: 39%

B. This service reflects new technology that has become more familiar: Yes 30% No 33%

C. Patients requiring this service are now:

More complex (more work) 59% Less complex (less work) 0% No change in complexity 11%

D. The typical site-of-service has changed:

From outpatient to inpatient 7% From inpatient to outpatient 0% No change 66%

SS Rec Summary

ISSUE: Valve replacements and CABG

TAB: 12

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF				#DIV/0!						0																												
CURRENT	33405	Replacement, aortic v		0.105			41.32			769	60	15	20			198			40	1		3	2	1	1.0								1	1				
STS Database data	33405	Replacement,	78332	0.112			42.58			768	60	15	20			197			40	1		3	2	1	1.0								1	1				
REC	33405	Replacement, aortic v		0.106			41.32			768	60	15	20			197			40	1		3	2	1	1.0								1	1				

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF				#DIV/0!						0																												
CURRENT	33430	Replacement, mitral v		0.109			50.93			904	60	15	20			223			40	2		3	2	1	1								1	2				
STS Database data	33430	Replacement,	15374	0.112			52.59			913	60	15	20			232			40	2		3	2	1	1								1	2				
REC	33430	Replacement, mitral v		0.105			50.93			913	60	15	20			232			40	2		3	2	1	1								1	2				

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF				#DIV/0!						0																												
CURRENT	33533	Coronary artery bypa		0.100			33.75			675	60	15	20			151			40	1		3	1	1	1.0								1	1				
STS Database data	33533	Coronary artery bypa		0.106			35.39			682	60	15	20			158			40	1		3	1	1	1.0								1	1				
REC	33533	Coronary artery bypa		0.103			34.98			682	60	15	20			158			40	1		3	1	1	1.0								1	1				

		2000 - 2004 Database Data	2006-2010 Database Data
2		33430	33430
3	**ADULT CARDIAC STATISTICS**	Replacement, mitral valve, with cardiopulmonary bypass	Replacement, mitral valve, with cardiopulmonary bypass
5	**Number of Patients**	13,828	15,374
6			
7			
8	**Preoperative Characteristics**		
9	Age	60.9	60.7
10	% Age > 65	45%	43%
11	% Male	39%	40%
12	Weight (Kg)	77.0	78.5
13	% Diabetes	13%	19%
14	% CHF	53%	52%
15	% Cerebrovascular Disease	11%	15%
16	% Peripheral Vascular Disease	6%	6%
17	% COPD	79%	73%
18	Creatinine Preop	1.3	1.3
19	Ejection Fraction	54.9	56.0
20	% Prev CV Intervention	12%	15%
21	% Previous PCI	10%	8%
22	% Inotropic Agents (preop)	4%	4%
23	% IABP (preop)	5%	6%
24	% Cardiogenic Shock (preop)	3%	3%
25	% Resuscitation to OR	1%	1%
26	% Antiplatelet Agents (preop)	7%	3%
27	% ADP Blocker (preop)	3%	3%
28	% IIbIIa Inhibitor (preop)	0%	0%
29	Predicted Morbidity or Mortality	NA	NA
30	Predicted Prolonged Ventilaion	NA	NA
31	Predicted LOS (Prolonged)	NA	NA
32	Predicted CVA	NA	NA
33	Predicted Reop	NA	NA
34	Predicted Renal Failure	NA	NA
35	Predicted Deep Sternal Wound Infection	NA	NA
36	Predicted LOS (WNL)	NA	NA
37	**Intraservice Period**		
38	**Intraservice Time**	223	231
39	% CPB Used	93%	100%
40	Perfusion Time	118	125
41	Aortic Clamp Time	87	92
42	% Intraop Blood Products	52%	54%
43	Units Intraop RBCs	2.3	2.3
44	Units Intraop Platelets	2.0	2.0
45	Units Intraop Cryoprecipitate	0.3	0.4
46	Units Intraop FFP	1.2	1.3
47	**Postoperative Period**		
48	% ICU	100%	99%

		2000 - 2004 Database Data	2006-2010 Database Data
2		33430	33430
3	**ADULT CARDIAC STATISTICS**	Replacement, mitral valve, with cardiopulmonary bypass	Replacement, mitral valve, with cardiopulmonary bypass
5	**Number of Patients**	13,828	15,374
49	Total ICU Hours	74	87
50	Total Ventilator Hours	24	28
51	% Postop Blood Products	52%	55%
52	Units Postop RBCs	2.4	2.5
53	Units Postop Platelets	1.4	0.9
54	Units Postop Cryoprecipitate	0.4	0.4
55	Units Postop FFP	1.2	1.1
56	Postoperative LOS (Days)	8.6	9.0
57	Readmit <30 days	12%	14%
58	Mortality (30 Day)	4.1%	4.4%
59	Mortality (Operative)	3.6%	3.8%
60	**Complications**		
61	Any Hospital Complication	43.2%	48.5%
62	Atrial Fibrillation	24.0%	25.2%
63	Prolonged Ventilation	9.1%	15.2%
64	Renal Failure	3.8%	4.5%
65	Re-Intubated During Hospital Stay	3.6%	3.7%
66	Pneumonia	2.9%	3.6%
67	Gastro-Intestinal Complication	2.6%	2.1%
68	Cardiac Arrest	1.7%	5.2%
69	Heart Block	4.7%	1.5%
70	PostOp Stroke >72 Hours	1.7%	2.3%
71	Infection - Septicemia	1.4%	1.4%
72	Multi-System Failure	1.1%	1.2%
73	Transient Neurologic Deficit	1.5%	0.7%
74	Dialysis (Newly Required)	0.8%	8.2%
75	Anticoagulant Complication	1.8%	2.1%
76	Other Complication	0.4%	11.1%
77	Perioperative MI	0.4%	1.6%
78	Continuous Coma >=24 Hours	0.6%	0.5%
79	Infection - Leg	0.1%	0.0%
80	Acute Limb Ischemia	0.2%	0.3%
81	Pulmonary Embolism	0.2%	0.1%
82	Cardiac Tamponade	0.4%	0.1%
83	Infection - Sternum Deep	0.2%	0.1%
84	Aortic Dissection	0.0%	0.0%
85	Illiac/Femoral Dissection	0.0%	0.0%
86	Infection - Thoracotomy	0.0%	0.1%

CPT Code: 33405, 33430, 33533
Specialty Society('s): STS

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

33405 - Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

33430 - Replacement, mitral valve, with cardiopulmonary bypass

33533 - Coronary artery bypass, using arterial graft(s); single arterial graft

Global Period: 090 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

There are no changes to the practice expense inputs for these three codes

Please describe in detail the clinical activities of your staff:

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE		REFERENCE CODE	
2				33405	33405	33430	33430	33533	33533
3	**Meeting Date:** **Tab: 40** **Specialty:**	**CMS Code**	**Staff Type**	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, mitral valve, with cardiopulmonary bypass	Replacement, mitral valve, with cardiopulmonary bypass	Coronary artery bypass, using arterial graft(s); single arterial graft	Coronary artery bypass, using arterial graft(s); single arterial graft
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**90**	**90**	**90**	**90**	**90**	**90**
6	**TOTAL CLINICAL LABOR TIME**	L0151A	RN	**176.0**	**161.0**	**212.0**	**200.0**	**152.0**	**152.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L0151A	RN	**75.0**	**60.0**	**75.0**	**60.0**	**60.0**	**60.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L0151A	RN	**12.0**	**12.0**	**12.0**	**15.0**	**12.0**	**12.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L0151A	RN	**89.0**	**89.0**	**125.0**	**125.0**	**80.0**	**80.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L0151A	RN	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L0151A	RN	**20**	**20**	**20**	**20**	**20**	**20**
14	Schedule space and equipment in facility	L0151A	RN	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	L0151A	RN	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	L0151A	RN	**7**	**7**	**7**	**7**	**7**	**7**
17	Other Clinical Activity - *specify: for reference code 33406 and codes 33405 and 33430: Additional coordination between multiple specialties for complex procedures (tests, meds, scheduling, etc) prior to patient arrival at site of service.*	L0151A	RN	**15**	**0**	**15**	**0**		
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available								
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure								
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff								
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Other Clinical Activity - *specify:*								
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)								
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L0151A	RN	**12**	**12**	**12**		**12**	**12**
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L0151A	RN				**15**		
42	**End: Patient leaves office**								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE		REFERENCE CODE	
2				33405	33405	33430	33430	33533	33533
3	**Meeting Date:** **Tab: 40** **Specialty:**	**CMS Code**	**Staff Type**	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, mitral valve, with cardiopulmonary bypass	Replacement, mitral valve, with cardiopulmonary bypass	Coronary artery bypass, using arterial graft(s); single arterial graft	Coronary artery bypass, using arterial graft(s); single arterial graft
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**90**	**90**	**90**	**90**	**90**	**90**
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27					**1**	**1**
49	99213 36 minutes		36	**1**	**1**	**2**	**2**		
50	99214 53 minutes		53	**1**	**1**	**1**	**1**	**1**	**1**
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**89.0**	**89.0**	**125.0**	**125.0**	**80.0**	**80.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	pack, minimum multi-specialty visit	SA048	pack	**2**	**2**	**3**	**3**	**2**	**2**
57	pack, post-op incision care (staple)	SA052	pack	**1**	**1**	**1**	**1**	**1**	**1**
58									
59									
60									
61									
62	**EQUIPMENT**	**CODE**							
63	table, power	EF023		**89**	**89**	**125**	**125**	**80**	**80**
64	light, exam	EQ168		**89**	**89**	**125**	**125**	**80**	**80**
65									
66									
67									

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE		REFERENCE CODE	
2				33405	33405	33430	33430	33533	33533
3	**Meeting Date:** **Tab: 40** **Specialty:**	**CMS Code**	**Staff Type**	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, mitral valve, with cardiopulmonary bypass	Replacement, mitral valve, with cardiopulmonary bypass	Coronary artery bypass, using arterial graft(s); single arterial graft	Coronary artery bypass, using arterial graft(s); single arterial graft
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**90**	**90**	**90**	**90**	**90**	**90**
6	**TOTAL CLINICAL LABOR TIME**	L0151A	RN	**176.0**	**176.0**	**212.0**	**215.0**	**152.0**	**152.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L0151A	RN	**75.0**	**75.0**	**75.0**	**75.0**	**60.0**	**60.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L0151A	RN	**12.0**	**12.0**	**12.0**	**15.0**	**12.0**	**12.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L0151A	RN	**89.0**	**89.0**	**125.0**	**125.0**	**80.0**	**80.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L0151A	RN	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L0151A	RN	**20**	**20**	**20**	**20**	**20**	**20**
14	Schedule space and equipment in facility	L0151A	RN	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	L0151A	RN	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	L0151A	RN	**7**	**7**	**7**	**7**	**7**	**7**
17	Other Clinical Activity - *specify: for reference code 33406 and codes 33405 and 33430: Additional coordination between multiple specialties for complex procedures (tests, meds, scheduling, etc) prior to patient arrival at site of service.*	L0151A	RN	**15**	**15**	**15**	**15**		
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available								
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure								
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff								
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Other Clinical Activity - *specify:*								
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)								
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L0151A	RN	**12**	**12**	**12**		**12**	**12**
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L0151A	RN				**15**		
42	**End: Patient leaves office**								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE		REFERENCE CODE	
2				33405	33405	33430	33430	33533	33533
3	**Meeting Date:** **Tab: 40** **Specialty:**	**CMS Code**	**Staff Type**	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Replacement, mitral valve, with cardiopulmonary bypass	Replacement, mitral valve, with cardiopulmonary bypass	Coronary artery bypass, using arterial graft(s); single arterial graft	Coronary artery bypass, using arterial graft(s); single arterial graft
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**90**	**90**	**90**	**90**	**90**	**90**
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
47	99211 16 minutes		16						
48	99212 27 minutes		27					**1**	**1**
49	99213 36 minutes		36	**1**	**1**	**2**	**2**		
50	99214 53 minutes		53	**1**	**1**	**1**	**1**	**1**	**1**
51	99215 63 minutes		63						
52	**Total Office Visit Time**			**89.0**	**89.0**	**125.0**	**125.0**	**80.0**	**80.0**
53	Other Clinical Activity - *specify:*								
54	**End: with last office visit before end of global period**								
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
56	pack, minimum multi-specialty visit	SA048	pack	**2**	**2**	**3**	**3**	**2**	**2**
57	pack, post-op incision care (staple)	SA052	pack	**1**	**1**	**1**	**1**	**1**	**1**
58									
59									
60									
61									
62	**EQUIPMENT**	**CODE**							
63	table, power	EF023		**89**	**89**	**125**	**125**	**80**	**80**
64	light, exam	EQ168		**89**	**89**	**125**	**125**	**80**	**80**
65									
66									
67									

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Comparison of coronary bypass surgery with drug-eluting stenting for the treatment of left main and/or three-vessel disease: 3-year follow-up of the SYNTAX trial

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Aims Long-term randomized comparisons of percutaneous coronary intervention (PCI) to coronary artery bypass grafting (CABG) in left main coronary (LM) disease and/or three-vessel disease (3VD) patients have been limited. This analysis compares 3-year outcomes in LM and/or 3VD patients treated with CABG or PCI with TAXUS Express stents.

Methods and results SYNTAX is an 85-centre randomized clinical trial ($n = 1800$). Prospectively screened, consecutive LM and/or 3VD patients were randomized if amenable to equivalent revascularization using either technique; if not, they were entered into a registry. Patients in the randomized cohort will continue to be followed for 5 years. At 3 years, major adverse cardiac and cerebrovascular events [MACCE: death, stroke, myocardial infarction (MI), and repeat revascularization; CABG 20.2% vs. PCI 28.0%, $P < 0.001$], repeat revascularization (10.7 vs. 19.7%, $P < 0.001$), and MI (3.6 vs. 7.1%, $P = 0.002$) were elevated in the PCI arm. Rates of the composite safety endpoint (death/stroke/MI 12.0 vs. 14.1%, $P = 0.21$) and stroke alone (3.4 vs. 2.0%, $P = 0.07$) were not significantly different between treatment groups. Major adverse cardiac and cerebrovascular event rates were not significantly different between arms in the LM subgroup (22.3 vs. 26.8%, $P = 0.20$) but were higher with PCI in the 3VD subgroup (18.8 vs. 28.8%, $P < 0.001$).

Conclusions At 3 years, MACCE was significantly higher in PCI- compared with CABG-treated patients. In patients with less complex disease (low SYNTAX scores for 3VD or low/intermediate terciles for LM patients), PCI is an acceptable revascularization, although longer follow-up is needed to evaluate these two revascularization strategies.

Keywords SYNTAX • Left main • Multivessel disease • PCI • CABG • Stent thrombosis

Introduction

Coronary artery bypass graft surgery (CABG) has been considered the optimum revascularization treatment for patients with *de novo* left main (LM) disease and/or three-vessel disease (3VD). In the past two decades, percutaneous coronary intervention (PCI) has emerged as a possible alternative in patients with complex coronary disease as stent design, procedural technique, and adjunctive medical therapy have improved.[1,2] Recent revisions to revascularization guidelines have reflected these improvements in PCI outcomes for patients with complex coronary disease.[3,4] In general, during the first year after the index procedure, PCI has been found to be as safe as CABG in patients with severe coronary artery disease; however, the rates of retreatment are significantly

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higher and PCI failed to show non-inferiority compared with CABG due to increased repeat revascularization.[5,6] Additionally, the occurrence of very late stent thrombosis (ST), although rare, is a concern for patients treated with PCI,[7] whereas the risk of stroke is increased following CABG.[6,8–10]

The overall goal of the SYNTAX trial is to assess the most appropriate revascularization strategy by randomizing patients to either PCI with TAXUS Express stents or CABG. The innovative angiographic SYNTAX score was also developed to help prospectively determine the complexity of the coronary anatomy before embarking on intervention.[11,12] The average number of stents and total stented length implanted in SYNTAX is higher than any other contemporary drug-eluting stent vs. CABG study. The primary endpoint at 1 year was not met; the non-inferiority of PCI compared with CABG was not demonstrated and CABG proved to be superior. After 1 year, no differences were observed in safety outcomes (death, stroke, and MI) between CABG and PCI patients, although the rate of revascularization and overall major adverse cardiac and cerebrovascular events (MACCE) was significantly increased in PCI patients and stroke was significantly increased in CABG patients. The current study reports the 3-year outcomes from the SYNTAX trial.

Methods

Study design, subject selection, and follow-up

The SYNergy between PCI with TAXUS and Cardiac Surgery (SYNTAX) trial is a multinational, randomized (1:1) study comparing clinical outcomes after drug-eluting PCI using the TAXUS Express stent (Boston Scientific, Natick, MA, USA) or CABG in patients with 3VD and/or LM disease. Patients in whom equivalent and comparable revascularization could be achieved by either CABG or PCI (as determined by the cardiothoracic surgeon and interventional cardiologist of the 'Heart Team') were randomized ($n = 1800$; CABG $n = 897$ and PCI $n = 903$). In the LM group, patients could have isolated LM disease or LM plus 1, 2, or 3VD. Patients considered unsuitable for one of the treatment options were enrolled in parallel, nested registries (the PCI registry for CABG-ineligible patients, $n = 198$; CABG registry for PCI-ineligible patients, $n = 1077$). Three-year post-allocation follow-up was assessed by clinic visit; further follow-up will be conducted at 4 (telephone call or clinic visit) and 5 years (clinic visit) post-treatment allocation.

The study protocol was reviewed and approved by an Institutional Review Board/Ethics Committee at each participating site. Before enrolment in the study, each patient provided written informed consent. SYNTAX is registered on the National Institute of Health website (www.clinicaltrials.gov) as NCT00114972. The study design, including details on sample size determination, randomization scheme, and primary endpoint results have previously been described in detail.[6,13]

Definitions

The primary clinical endpoint of SYNTAX was the composite of MACCE [all-cause death, cerebrovascular accident (CVA/stroke), MI, and repeat revascularization] through 12-month post-allocation. Patients were treated with the intention of complete revascularization of all vessels/lesions (reference diameter >1.5 mm, stenosis $\geq 50\%$) identified at the Heart Team conference. Completeness of revascularization was assessed post-procedure by the investigator. All deaths were considered cardiac unless an unequivocal, non-cardiac cause could be established. Cerebrovascular events, or stroke, were defined as focal neurological deficits of central origin lasting >72 h resulting in permanent brain damage or body impairment. The definition of MI was based on previous studies.[14–16] Briefly, MI was defined in relation to intervention status as follows: (i) after allocation but before treatment: Q-wave [new pathological Q-waves in ≥ 2 leads lasting ≥ 0.04 s with creatine kinase-MB (CK-MB) levels elevated above normal] and non-Q-wave MI [elevation of CK levels $>2\times$ the upper limit of normal (ULN) with positive CK-MB or elevation of CK levels to $>2\times$ ULN without new Q-waves if no baseline CK-MB was available]; (ii) <7 days after intervention: new Q-waves and either peak CK-MB/total CK $>10\%$ or plasma level of CK-MB $5\times$ ULN; and (iii) ≥ 7 days after intervention: new Q-waves or peak CK-MB/total CK $>10\%$ or plasma level of CK-MB $5\times$ ULN or plasma level of CK $5\times$ ULN. The CK/CK-MB enzyme levels were obtained and measured by a core laboratory for all randomized patients. Per protocol (symptomatic) graft occlusion (GO) and ST were defined as an acute coronary syndrome with confirmed occlusion within or adjacent to a previously treated graft (GO) or lesion (ST) and/or Q-wave MI in the treated vessel territory within 30 days of the index procedure. Additionally, ST was adjudicated according to the Academic Research Consortium (ARC) definitions as definite or probable and by timing of the event: acute (≤ 1 day post-procedure), subacute (2 to ≤ 30 days), late (>30 to ≤ 365 days), and very late (>365 days).[17] All MACCE, GO, and ST events were adjudicated by an independent, Clinical Events Committee which included a neurologist.

SYNTAX score

Angiograms were scored according to the SYNTAX score algorithm (www.syntaxscore.com)[12] by the Angiographic Core Laboratory (Cardialysis BV, Rotterdam, The Netherlands).

Statistical methods

Analyses were conducted using SAS System Software, Version 8.0 or higher (SAS Institute, Cary, NC, USA). Analyses of the randomized cohort were based on the intent-to-treat principle and in the registries were performed in an as-treated manner. Time-to-event rates are presented for overall 3-year data. Discrete variables are presented as counts and percentages. Differences in the time-to-event curves between the treatment groups were evaluated by a two-sided log-rank test. All tests of interaction were from a χ^2 test from a logistic regression model including the factors of interest and the interaction term. A χ^2 or Fisher's exact test was used, as appropriate, for discrete variables.

Results

The baseline clinical characteristics of the randomized treatment groups were well balanced and have previously been published with clinical outcomes up to 1 year of follow-up.[6] Over 3 years of follow-up, 45 CABG patients withdrew their consent, 12 patients were lost to follow-up and 13 patients had no 3-year clinical visit leading to complete data sets in 92.2% ($n = 827$) of patients in the CABG group. Nine PCI patients withdrew their consent, an additional three PCI patients were lost to follow-up and six patients had no 3-year clinical visit resulting in complete clinical follow-up in 98.0% ($n = 885$) of the PCI group at 3 years (*Figure 1*).

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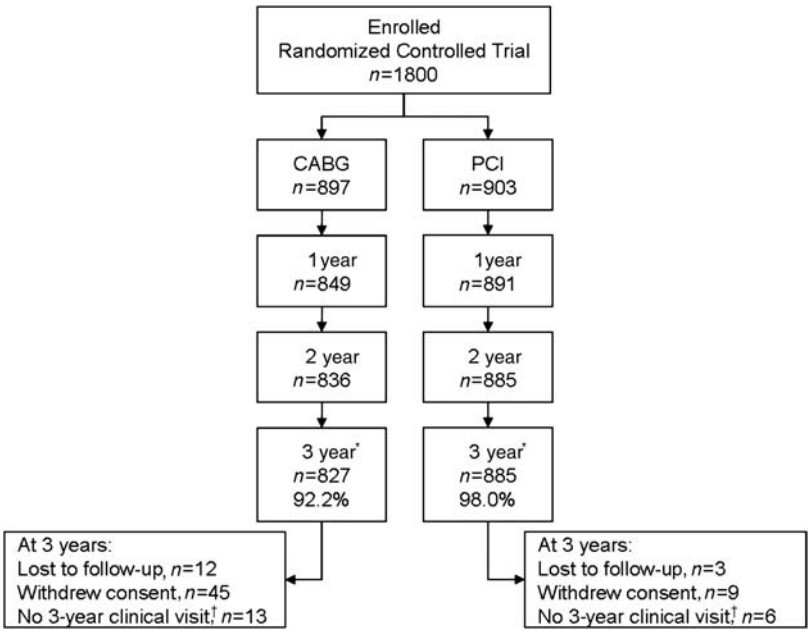

Figure 1 Patient disposition. *Patients evaluable for 3-year major adverse cardiac and cerebrovascular events. †Patients with no 3-year clinical follow-up also includes those patients whose follow-up occurred too early to meet the requirement for adequate follow-up for 3-year major adverse cardiac and cerebrovascular event determination (percutaneous coronary intervention arm $n = 2$). Patients with no 3-year clinical visit have not discontinued their participation in the trial.

Major adverse cardiac and cerebrovascular events at 3-year follow-up in the overall randomized cohort

The rates of MACCE and MACCE components through 3 years, analysed in a time-to-event manner, are presented in *Figures 2* and *3*. Total MACCE through 3 years was significantly higher in the PCI arm compared with the CABG arm (CABG 20.2% vs. PCI 28.0%; $P < 0.001$; *Figure 2A* and *3*). Increased repeat revascularization in the PCI arm was one of the drivers of the difference in MACCE rates between groups at 3 years (CABG 10.7% vs. PCI 19.7%; $P < 0.001$; *Figures 2B* and *3*). The composite safety endpoint of death/stroke/MI was not significantly different between treatment groups 3-year post-randomization (CABG 12.0% vs. PCI 14.1%; $P = 0.21$; *Figures 2C* and *3*). Death from all causes was not different between the treatment groups at 3 years (CABG 6.7% vs. PCI 8.6%; $P = 0.13$, *Figures 2D* and *3*). The cumulative rate of cardiac death was significantly higher at 3 years in the PCI arm (CABG 3.6% vs. PCI 6.0%; $P = 0.02$; *Figure 3*). At 3 years, the incidence of stroke was not significantly different between CABG- (3.4%) and PCI-treated patients (2.0%, $P = 0.07$; *Figures 2E* and *3*). The MI rate at 3 years was 3.6% in the CABG and 7.1% in the PCI cohort ($P = 0.002$; *Figures 2F* and *3*). The rate of post-procedure per protocol GO was 3.2% per patient ($n = 26$) and 1.2% per graft (25/2026) at 3 years, with six patients experiencing a documented GO between the second and third year. The 3-year post-procedure per protocol ST rate was 4.1% per patient ($n = 36$) and 1.2% per stent (45/3715) with four STs occurring more than 2 years after the index procedure. Binary rates of ARC definite/probable ST were 7.4% per patient and 1.6% per stent at 3 years with 23 patients experiencing an ST after the first year of follow-up.

At 3 years, significantly more PCI-randomized patients were receiving dual antiplatelet therapy (DAPT), aspirin therapy, or single antiplatelet therapy compared with patients in the CABG arm (*Table 1*).

Myocardial infarction

A total of 31 CABG-treated ($n = 33$ MI) and 62 PCI-treated ($n = 65$ MI) patients experienced an MI within 3 years of follow-up ($P = 0.002$). The majority of MI occurred periprocedurally in the CABG arm; 4 MIs occurred after randomization but before treatment and an additional 22 occurred within 7 days of the index procedure (see Supplementary material online, *Figure S1*). Fifteen MIs were Q-wave and 11 MIs were non-Q-wave MI (see Supplementary material online, *Figure S1*). In the PCI arm, 2 MIs occurred in patients before and 30 MIs within 7 days following the index treatment (see Supplementary material online, *Figure S1*). The MIs $\geq$7 days after the index procedure in the PCI arm were distributed evenly through the 3 years of follow-up; 13 MIs occurred in the first year of follow-up and 10 MIs occurred in both the second and third year of follow-up. Approximately half of the MIs in the PCI arm were non-Q-wave MI (33/65; see Supplementary material online, *Figure S1*).

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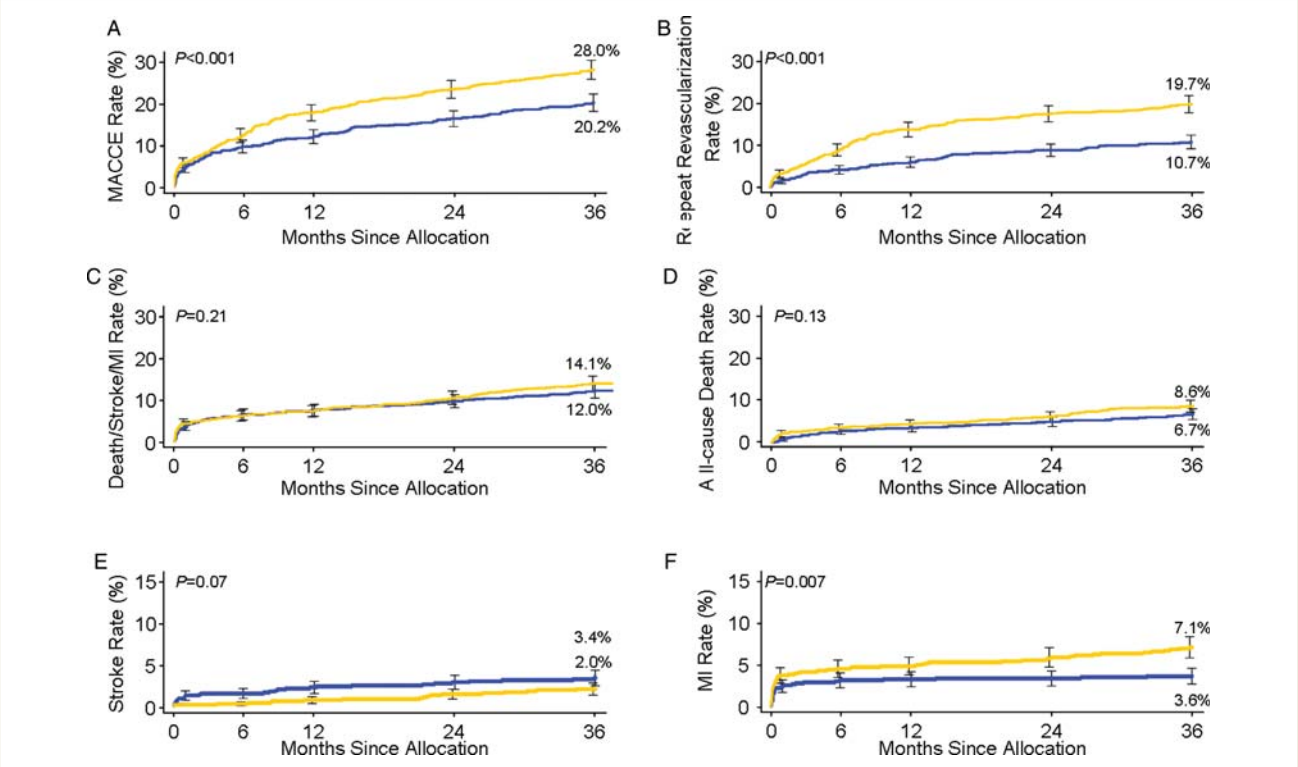

Figure 2 Rates of clinical outcomes among randomized treatment groups. Time-to-event curves in patients treated with coronary artery bypass grafting (blue line) or percutaneous coronary intervention (yellow line) for the composite of major adverse cardiac and cerebrovascular events (*A*), repeat revascularization (*B*), death/stroke/myocardial infarction (*C*), all-cause death (*D*), stroke (*E*), and myocardial infarction (*F*) to 3 years. *P*-values from log-rank test.

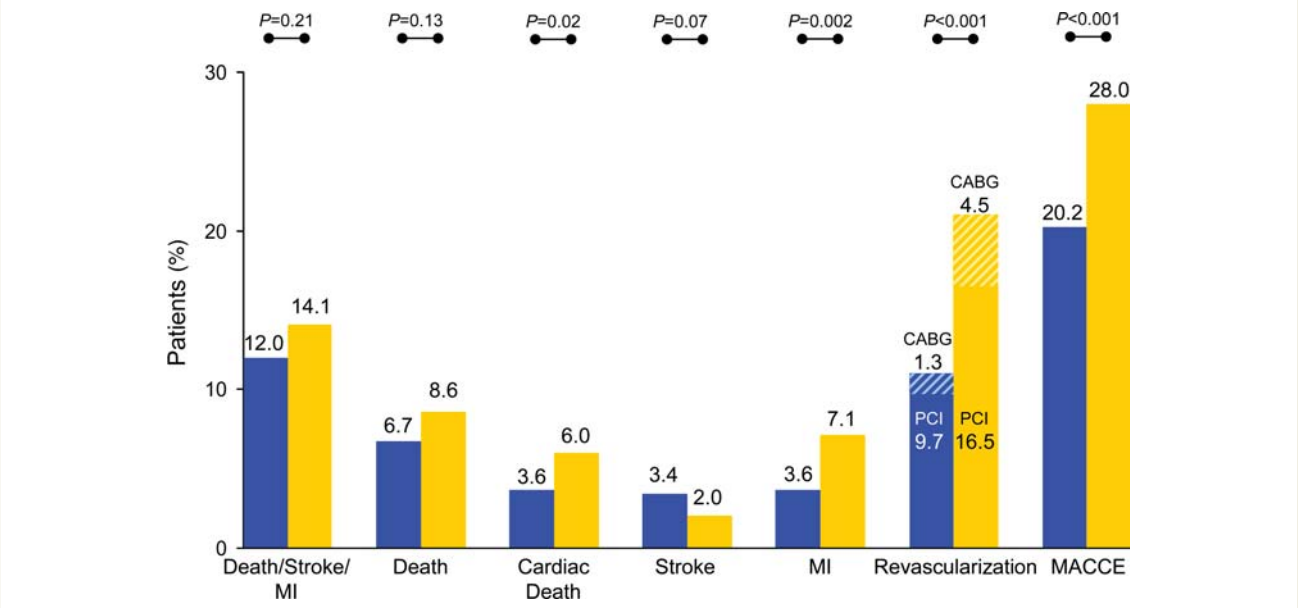

Figure 3 Rates of clinical outcomes among randomized treatment groups. Three-year clinical outcomes in coronary artery bypass grafting (blue bars) or percutaneous coronary intervention (yellow bars). Repeat revascularization is broken down into repeat percutaneous coronary intervention (yellow or blue bars) and repeat coronary artery bypass grafting (striped yellow or blue bars). The Kaplan–Meier event rates, *P*-value from log-rank test.

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Table 1 Cardiac-related medications at 3-year follow-up

Medication type	CABG[a]	PCI[a]	*P*-value[b]
Any cardiac-related medication (%)	99.3 (745/750)	99.6 (795/798)	0.49
Dual antiplatelet therapy (aspirin and antiplatelet) (%)	8.5 (64/750)	32.8 (262/798)	<0.001
Aspirin alone	83.3 (625/750)	87.5 (698/798)	0.02
Antiplatelet alone, any	16.3 (122/750)	41.7 (333/798)	<0.001
Thienopyridine antiplatelet alone	12.4 (93/750)	36.6 (292/798)	<0.001
Other antiplatelet medications (%)	4.0 (30/750)	5.6 (45/798)	0.13
Coumadin derivatives (%)	6.8 (51/750)	3.6 (29/798)	0.005
Statin therapy (%)	85.5 (641/750)	86.6 (691/798)	0.52
β-Blockers (%)	77.2 (579/750)	77.2 (616/798)	0.99
ACE-inhibitors (%)	52.5 (394/750)	52.4 (418/798)	0.95
Calcium channel blockers (%)	22.7 (170/750)	25.7 (205/798)	0.17
Angiotensin II receptor antagonists (%)	19.2 (144/750)	21.1 (168/798)	0.36
Anti-arrhythmics (amiodarone) (%)	2.5 (19/750)	0.8 (6/798)	0.006
H2 receptor blockers (%)	12.3 (92/750)	13.4 (107/798)	0.50

[a]Values based on an intent-to-treat analysis.
[b]Binary rates *P*-value from χ^2 test.

Graft occlusion and stent thrombosis

In the CABG arm, MI was a consequence of GO in 6 of 26 CABG-randomized GO patients; each was successfully revascularized. The majority of GO patients in the CABG arm did not experience an MI but did require repeat revascularization (17/26). No events occurred after the GO in three patients. In the PCI arm, 10 of 36 ST patients experienced a fatal MI and 1 patient died after an emergency re-CABG. Eleven patients experienced an MI related to the ST and were successfully revascularized. Fourteen patients (of 36) received revascularization after the ST in the PCI arm. Of the nine patients who experienced a very late ST (>1 year) in the PCI arm, five were receiving DAPT while four were taking aspirin alone. In patients receiving aspirin therapy alone, clopidogrel had been discontinued in two patients 2–4 weeks prior to the ST.

Subgroup analyses

The a priori statistical method was a closed hierarchical testing procedure comparing the overall randomized patient population (including patients with either LM and/or 3VD) first with the 3VD and LM subgroups being compared subsequently only if non-inferiority was concluded for the overall comparison. As non-inferiority was not shown in the overall cohort, specific information for each subgroup should be considered observational and hypothesis-generating only. The 3-year death/stroke/MI, repeat revascularization, and MACCE rates are shown separately for the pre-specified 3VD, LM, and diabetic subgroups of the randomized cohort (*Figure 4*).

There were no significant interactions between LM/3VD status and treatment group for 3-year MACCE or any of the components; the treatment effect of PCI compared with CABG was not significantly different between patients with LM or 3VD. Patients with 3VD treated with PCI experienced significantly more MACCE events, including increased repeat revascularization and combined death/stroke/MI, than those in the CABG arm (*Figure 4A*). Overall mortality (9.5 vs. 5.7%, $P = 0.02$) and cardiac death were significantly increased in 3VD patients treated with PCI (6.2 vs. 2.9%, $P = 0.01$). In the LM cohort, the rates of MACCE and death/stroke/MI were not significantly different in PCI- and CABG-treated patients. The 3-year rate of repeat revascularization was increased in PCI-treated LM patients (*Figure 4B*). There was no difference in all-cause or cardiac death rates in CABG- or PCI-treated patients with LM disease (all-cause: CABG 8.4% vs. PCI 7.3%, $P = 0.64$; cardiac death 4.6 vs. 5.7%, $P = 0.48$). There were no significant interactions observed for the diabetic status and treatment group for 3-year MACCE or any of the components; the treatment effect of PCI compared with CABG was not different based on the diabetic status. The presence of diabetes was associated with increased rates of repeat revascularization and, consequently, MACCE in the PCI arm without increasing the rates of death/stroke/MI over 3 years of follow-up (*Figure 4*). Cardiac death was not significantly different between treatment groups in the subset of diabetic patients (4.8 vs. 8.8%, $P = 0.10$).

Impact of lesion complexity on clinical outcomes

The impact of lesion complexity on clinical outcomes was assessed by examining 3-year patient outcomes relative to their SYNTAX score (*Figure 5*). There was a significant interaction between the SYNTAX score tercile and treatment group for the 3-year outcomes of MACCE, death/stroke/MI, and death ($P = 0.025$, 0.088, and 0.084, respectively). The rates of MACCE and the individual MACCE components were not significantly different in patients with low SYNTAX scores (≤22) treated with either PCI or CABG (*Figure 5A*). In patients with intermediate SYNTAX scores

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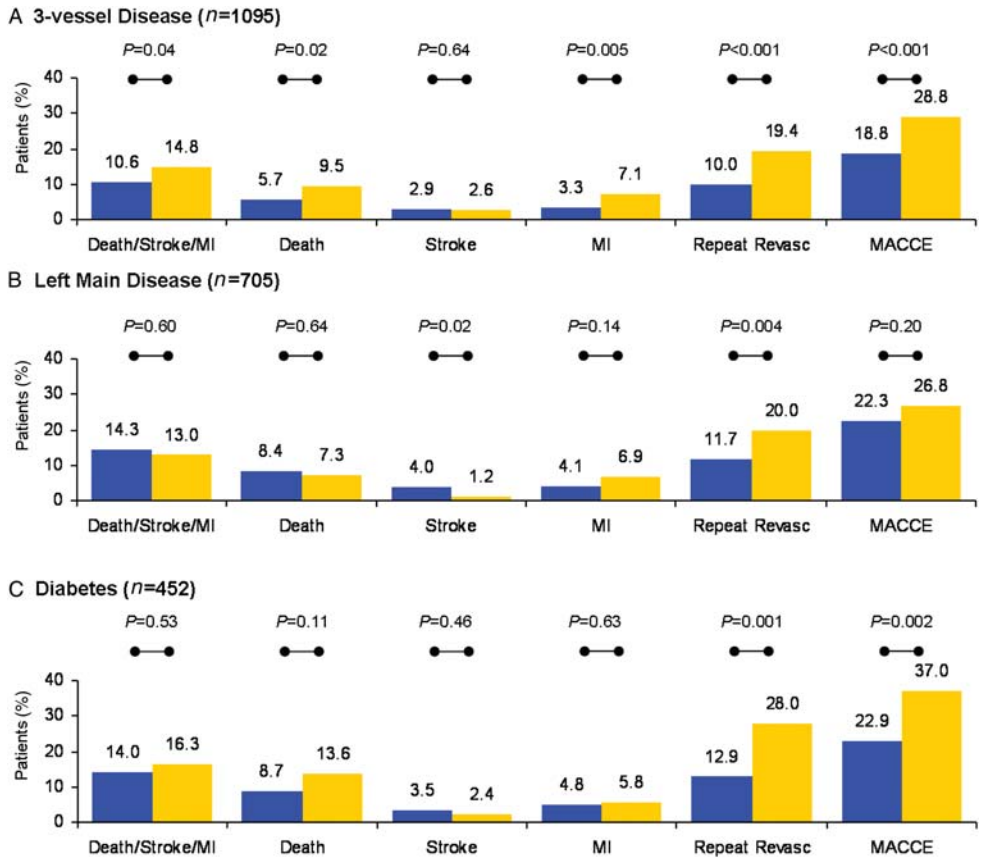

Figure 4 Three-year clinical outcomes according to the treatment group in patients with three-vessel disease, left main disease, or diabetes—death/stroke/myocardial infarction, all-cause death, stroke, myocardial infarction, repeat revascularization (repeat revasc), and major adverse cardiac and cerebrovascular event rates at 3 years in coronary artery bypass grafting (blue bars) or percutaneous coronary intervention-treated (yellow bars) patients with three-vessel (*A*) or left main (*B*) disease or diabetes (*C*). *P*-value from log-rank test.

(23–32), repeat revascularization rates were significantly higher in PCI-treated patients (CABG 10.1% vs. PCI 17.4%, $P = 0.01$), as were MI and MACCE rates (MI: CABG 3.2% vs. PCI 7.6%, $P = 0.02$; MACCE: 18.9 vs. 27.4%, $P = 0.02$; *Figure 5B*). In patients with the most complex anatomical disease (those with SYNTAX scores ≥33), MACCE and its components, apart from stroke, were significantly higher in patients treated with PCI (MACCE: CABG 19.5% vs. PCI 34.1%, $P < 0.001$, *Figure 5C*).

The three-way interaction between the treatment group, LM/3VD status, and SYNTAX score tercile was assessed for 3-year MACCE and components; there were no significant three-way interactions observed.

Patients with 3VD with SYNTAX scores in the lowest tercile exhibited similar MACCE rates between treatment arms (CABG 22.2% vs. PCI 25.8%, $P = 0.45$, *Figure 5D*). In those 3VD patients with intermediate or high SYNTAX scores, the rate of MACCE was significantly increased in favour of CABG (23–32: CABG 16.8% vs. PCI 29.4%, $P = 0.003$; ≥33: CABG 17.9% vs. PCI 31.4%, $P = 0.004$; *Figure 5E* and *F*). Myocardial infarction was significantly higher in the PCI arm of the 3VD intermediate SYNTAX score tercile (3.1 vs. 8.9%, $P = 0.01$). In 3VD patients with SYNTAX score ≥33, mortality (CABG 4.5% vs. PCI 11.1%, $P = 0.03$) and MI (1.9 vs. 7.2%, $P = 0.02$) were significantly higher in the PCI arm.

Major adverse cardiac and cerebrovascular event rates were not significantly different in patients with LM disease who had low or intermediate SYNTAX scores (0–22: CABG 23.0% vs. PCI 18.0%, $P = 0.33$; 23–32: CABG 23.4% vs. PCI 23.4%, $P = 0.90$; *Figure 5G* and *H*). In LM patients with the most complex anatomy (SYNTAX score ≥33), MACCE was significantly increased in PCI-treated patients (CABG 21.2% vs. PCI 37.3%, $P = 0.003$, *Figure 5I*) as was repeat revascularization (9.2 vs. 27.7%, $P < 0.001$). It is of note that the distribution of LM patients with concurrent 3VD was greatest in the 'high' SYNTAX score group in the overall patient population. Additionally, an increased proportion of distal LM lesions were found in the patients with 'high' SYNTAX scores compared with patients in the low and intermediate terciles.

Discussion

Similar to 1-year outcomes in SYNTAX, 3-year MACCE rates were significantly higher in the PCI arm compared with CABG-treated patients. At 3 years, the rate of MI in the PCI arm was significantly

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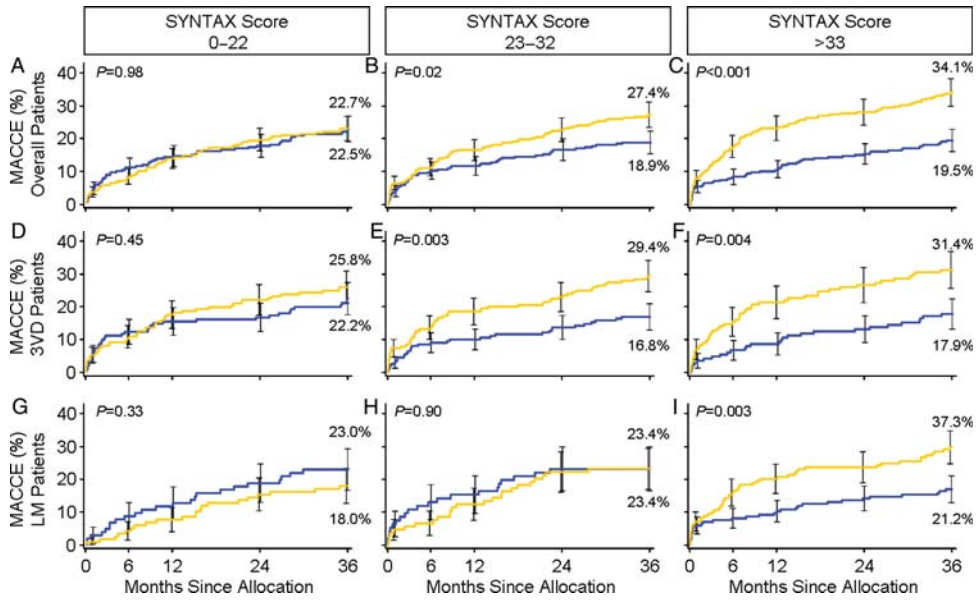

Figure 5 Major adverse cardiac and cerebrovascular event rates according to the subset, treatment group, and SYNTAX score category. Time-to-event curves in the coronary artery bypass grafting (blue line) or percutaneous coronary intervention (yellow line) overall cohorts to 3 years according to the low (0–22, *A*), intermediate (23–32, *B*), or high (≥33, *C*) SYNTAX scores. (*D*–*F*) Major adverse cardiac and cerebrovascular events in three-vessel disease patients with low, intermediate, or high SYNTAX scores, respectively. (*G*–*I*) Major adverse cardiac and cerebrovascular events in patients with left main disease with low, intermediate, or high SYNTAX scores. *P*-value from log-rank test.

increased compared with CABG patients and the difference in stroke rate between treatment arms was not significantly different unlike the outcomes after 1 year of follow-up. SYNTAX patients in the randomized cohort will continue to be followed for 5 years.

The trends in MACCE, death/stroke/MI, all-cause death, and repeat revascularization rates in the overall patient population seen in the first year of follow-up continued through the second and third year, although fewer total events occurred during each additional year of follow-up. Compared with outcomes after 1 year of follow-up, cardiac death was found to be significantly increased in the overall PCI-treated patient population, chiefly in those patients with higher SYNTAX scores at 3 years. The majority of cardiac deaths occurred within the first year of follow-up in both arms; ~40% occurred during the second and third year of follow-up. This difference was cumulative as the interval rates of cardiac death were not significant. Although stroke was significantly increased at 1 year of follow-up for CABG, no difference in stroke was seen during the interval of 1- and 3-year follow-up.

A difference in the MI rate between the two treatment groups was also noted after the report of the first year of follow-up. Two-thirds and one-half of all MIs were periprocedural (occurring within 7 days of the index procedure) in the surgical and PCI cohorts, respectively. The likely cause of the increased MIs in the PCI arm was due to restenosis/further revascularization in these patients with advanced diffuse disease or ST. When compared with CABG patients, MI rates were higher in the 3VD PCI group and not significantly different in the LM PCI cohort.

The clinical consequences of ST were more serious than for patients whose graft occluded. This may be due to the redundancy of patent native arteries available, the presence of collateral vessels in patients undergoing CABG which can be recruited during the process of progressive GO, and to GO being more likely to occur in patients with small target-vessel diameter.[18] The very late ST rate in SYNTAX was higher than in previous studies.[15,19] However, the lesion complexity and, consequently, the average number of stents implanted (4.6 stents per patient) and the average total stented length (86.1 mm) were higher than any other contemporary DES vs. CABG study.[6]

Overall MACCE rates were not significantly different in the pre-specified LM subgroup at 3 years. More PCI patients required reintervention compared with CABG-treated patients between these groups. The current US and European revascularization guidelines assign CABG a IA indication in most patients with 1, 2, or 3VD with low, intermediate, or high SYNTAX scores.[4,20] However, due to positive outcomes from other recent studies of LM patients, these guidelines have upgraded the indication for PCI in the LM artery from a Class III to a Class IIb (ACC/AHA)[4,20] and a Class IIb C to IIa B (ESC-EACTS)[3] indication in patients with isolated LM (ostial or trunk) and with associated 1VD. Additionally, the ESC-EACTS guidelines have also included the treatment of patients with 3VD and low SYNTAX scores as a Class IIa B indication.[3]

Both the presence of multivessel disease and diabetes are known to increase the risks associated with cardiovascular disease. In both of these subgroups, similar to the outcomes

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after 1 year of follow-up, the increase in MACCE and revascularization rates was maintained in PCI-treated patients.[6,8,21] Results from the FREEDOM (Future Revascularization Evaluation in Patients with Diabetes Mellitus: Optimal Management of Multivessel Disease)[22] and EXCEL (Evaluation of Xience Prime vs. Coronary Artery Bypass Surgery for Effectiveness of Left Main Revascularization) trials may provide further insight into the optimal treatment for multivessel, diabetic, and LM patients. Particularly, the impact of newer generation stents or stent platforms and the continued improvements in stenting technique will be seen in these trials.

Stratification of the randomized patient population into terciles derived from the baseline anatomical SYNTAX score confirmed the trends in MACCE rates that were found after 1 year of follow-up. Specifically, an intermediate (23–32) or high SYNTAX score (>33) was correlated with an increase in 3-year MACCE rates after percutaneous revascularization compared with surgery. Repeat revascularization, MI, and mortality were significantly higher in 3VD patients with the highest SYNTAX score. Thus, CABG remains the standard for more complex anatomy, whereas PCI in this trial demonstrated similar outcomes to CABG in patients with less complex disease, measured by lower SYNTAX score for 3VD and lower and intermediate scores for LM disease. The SYNTAX score has been successfully applied to other patient groups retrospectively and has shown value in predicting or correlating high anatomical complexity with increased adverse cardiac events making it an effective risk assessment tool.[23–27]

In the SYNTAX trial at 1 year, a significant difference in secondary prevention medical therapy was observed; patients in the surgical cohort were less likely to receive aspirin, thienopyridines, or statins compared with PCI patients. At 3 years, antiplatelet treatment was significantly different between the two treatment arms; patients in the CABG arm were significantly undertreated with single or DAPT than patients in the PCI arm.

Revascularization of all lesions identified at the heart team conference was required to meet the definition of complete revascularization. An anatomic definition of revascularization was used (treatment of lesions with reference diameter >1.5 mm, stenosis ≥50%) when compared with a functional classification (by fractional flow reserve testing). The rates of complete revascularization were 63 and 57% ($P = 0.005$) in the CABG and PCI arms, respectively.[6,13] The rate of complete revascularization in surgically treated patients was low compared with other studies in the literature, in part, due to differing definitions.[16,28,29] In the SYNTAX study, the investigators had to indicate which vessels they intended to graft or stent before actual treatment took place. Comparison with the treatment report revealed whether complete or incomplete revascularization was performed; this is in contrast to other studies where the operators indicated themselves whether they had performed a complete revascularization after the treatment had taken place.

The period of enrolment and index revascularization in SYNTAX occurred during a time of evolving strategies regarding complete revascularization in PCI. The results of FAME and other studies have shown that only those haemodynamically relevant stenoses should be treated unless symptoms of residual myocardial ischaemia arise requiring intervention upon non-culprit vessels.[30,31] Clinical outcomes may differ according to the completeness of revascularization.[32]

Study limitations

The SYNTAX trial was designed to overcome many limitations of previous comparisons of PCI and CABG. In spite of this, there is inadequate statistical power to detect differences in low-frequency events (e.g. stroke, MI) between arms. Additionally, analyses of the LM and 3VD subgroups, although sufficiently powered, can only be considered hypothesis-generating as SYNTAX did not meet its primary endpoint. The analyses of LM or 3VD patients by SYNTAX score were not pre-specified and should be considered exploratory and hypothesis-generating only. A larger number of patients withdrew from the CABG arm post-allocation ($n = 45$) than the PCI arm ($n = 9$), suggesting greater concern on the part of some patients to submit to the more invasive procedure. Sensitivity analyses suggest that the outcomes could have been influenced by non-evaluable patients if they all died. This is unlikely as a total of 57/827 CABG and 77/885 PCI patients who were evaluable died within 3 years of follow-up. The effect of this imbalance was minimized by including all data available up to the point of withdrawal (or lost to follow-up) were included in the analysis set and outcomes were analysed in an intent-to-treat manner. Details related to medical therapy were collected only at 1 and 3 years. Data regarding medical therapy at other intervals is lacking. Finally, the intermediate short (3-year) follow-up time may not provide an accurate estimate of long-term differences in outcomes between the two revascularization methods.

Conclusions

At 3 years, MACCE was increased in PCI patients compared with CABG; no difference was observed in the combined safety endpoint of death, MI, and stroke. Analysis of pre-specified subgroups suggests that for 3VD patients, MACCE, mortality, and the combined safety endpoint of death, MI, and stroke were increased with PCI, whereas for patients with LM disease, there were no significant differences in these outcomes with PCI. In relation to anatomical complexity, patients with less complex coronary anatomy (low SYNTAX scores in 3VD patients or low/intermediate SYNTAX scores in LM patients), PCI can be an acceptable alternative treatment option to CABG. Patients with more complex disease (3VD patients with intermediate/high SYNTAX scores and LM patients with high scores) have an increased risk of an MACCE event with PCI and CABG is the preferred treatment option.

Supplementary material

Supplementary material is available at *European Heart Journal* online.

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CARDIOVASCULAR FLASHLIGHT

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Right heart complications of ventriculoatrial shunt

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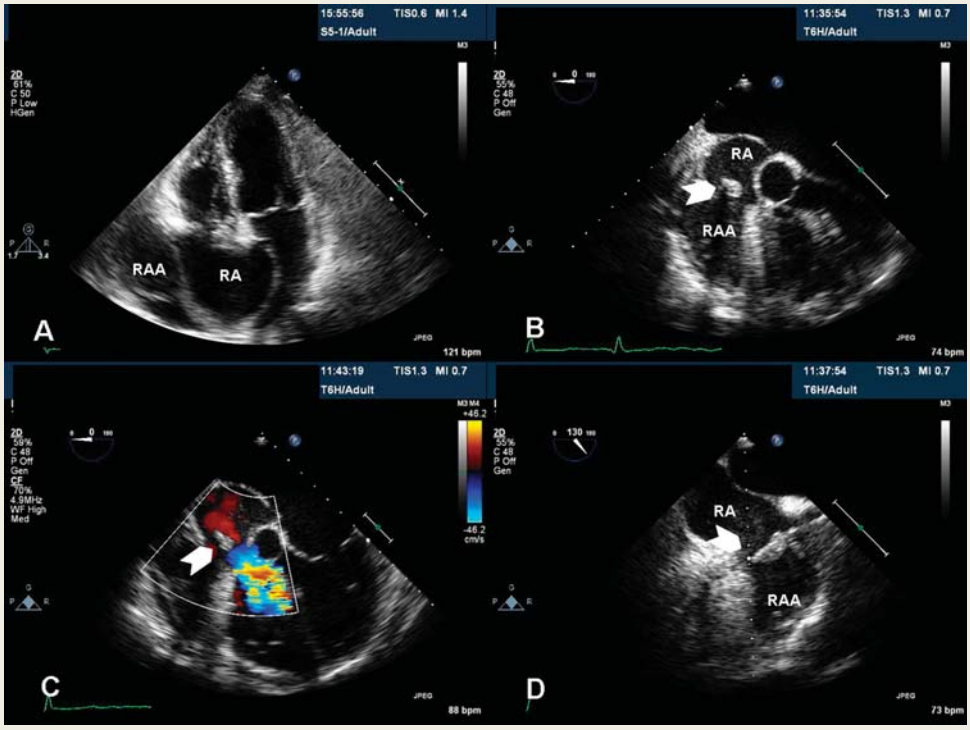

A 57-year-old male patient was treated in the intensive therapy unit for pneumonia and new-onset atrial fibrillation. He had a ventriculoatrial (VA) shunt since childhood which was placed for hydrocephalus. He had no other medical problems and had been lost to follow-up. Transthoracic echocardiography (*Panel A*) revealed significant calcific tricuspid stenosis, a dilated right atrium (RA), an unusually large right atrial appendage (RAA), and an aneurysmal interatrial septum. Subsequent transoesophageal echocardiography (*Panels B–D*) confirmed severe tricuspid stenosis with a mean gradient of 5 mmHg and turbulent transvalvular Doppler flow (*Panel C*). Furthermore, a mobile mass was noted at the tip of the VA shunt (*Panels B–D*, arrow) that was best visualized on the bicaval view (*Panel D*, arrow). This was most likely the result of an inflammatory response and thrombus. There was minimal tricuspid regurgitation and no pulmonary hypertension. Blood and urine cultures proved negative and empirical antibiotic therapy was given for 2 weeks. The patient made a good recovery and was discharged with anticoagulation and beta-blockers. At 6-monthly follow-up, he was found to be asymptomatic. Right heart complications can occur years after VA shunt placement. If symptomatic tricuspid stenosis develops, percutaneous valvuloplasty or surgical valve replacement should be considered. Surveillance of patients with VA shunts is currently poorly defined. There is also a paucity of published literature regarding the same. Our case illustrates the need for long-term clinical and echocardiographic follow-up in patients with VA shunts.

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ADULT CARDIAC INTENSITY REFERENCE TABLE

CPT	long descriptor	2012 Intensity
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	122
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	122
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	121
33545	Repair of postinfarction ventricular septal defect, with or without myocardial resection	121
35536	Bypass graft, with vein; splenorenal	120
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	119
33945	Heart transplant, with or without recipient cardiectomy	117
33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)	117
33530	Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)	115
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	114
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	114
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus	114
33860	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	114
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	113
33542	Myocardial resection (eg, ventricular aneurysmectomy)	112
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	111
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	108
35560	Bypass graft, with vein; aortorenal	107
33400	Valvuloplasty, aortic valve; open, with cardiopulmonary bypass	106
33460	Valvectomy, tricuspid valve, with cardiopulmonary bypass	105
33475	Replacement, pulmonary valve	102
33465	Replacement, tricuspid valve, with cardiopulmonary bypass	102
33464	Valvuloplasty, tricuspid valve; with ring insertion	101
33463	Valvuloplasty, tricuspid valve; without ring insertion	100
33141	Transmyocardial laser revascularization, by thoracotomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)	97
33510	Coronary artery bypass, vein only; single coronary venous graft	97
33474	Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass	94
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	94
35518	Bypass graft, with vein; axillary-axillary	91
33140	Transmyocardial laser revascularization, by thoracotomy; (separate procedure)	90
44950	Appendectomy;	78
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	77
35656	Bypass graft, with other than vein; femoral-popliteal	75
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	61
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers	52

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Adherence of Catheterization Laboratory Cardiologists to American College of Cardiology/American Heart Association Guidelines for Percutaneous Coronary Interventions and Coronary Artery Bypass Graft Surgery. What Happens in Actual Practice?

Edward L. Hannan, Michael J. Racz, Jeffrey Gold, Kimberly Cozzens, Nicholas J. Stamato, Tia Powell, Mary Hibberd and Gary Walford

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Adherence of Catheterization Laboratory Cardiologists to American College of Cardiology/American Heart Association Guidelines for Percutaneous Coronary Interventions and Coronary Artery Bypass Graft Surgery

What Happens in Actual Practice?

Edward L. Hannan, PhD; Michael J. Racz, PhD; Jeffrey Gold, MD; Kimberly Cozzens, MA; Nicholas J. Stamato, MD; Tia Powell, MD; Mary Hibberd, MD; Gary Walford, MD

Background—The American College of Cardiology and the American Heart Association have issued guidelines for the use of coronary artery bypass graft surgery (CABG) and percutaneous coronary interventions (PCI) for many years, but little is known about the impact of these evidence-based guidelines on referral decisions.

Methods and Results—A cardiac catheterization laboratory database used by 19 hospitals in New York State was used to identify treatment (CABG surgery, PCI, medical treatment, or nothing) recommended by the catheterization laboratory cardiologist for patients undergoing catheterization with asymptomatic/mild angina, stable angina, and unstable angina/non–ST-elevation myocardial infarction between January 1, 2005, and August 31, 2007. The recommended treatment was compared with indications for these patients based on American College of Cardiology/American Heart Association guidelines. Of the 16 142 patients undergoing catheterization who were found to have coronary artery disease, the catheterization laboratory cardiologist was the final source of recommendation for 10 333 patients (64%). Of these 10 333 patients, 13% had indications for CABG surgery, 59% for PCI, and 17% for both CABG surgery and PCI. Of the patients who had indications for CABG surgery, 53% were recommended for CABG and 34% for PCI. Of the patients with indications for PCI, 94% were recommended for PCI. For the patients who had indications for both CABG surgery and PCI, 93% were recommended for PCI and 5% for CABG surgery. Catheterization laboratory cardiologists in hospitals with PCI capability were more likely to recommend patients for PCI than hospitals in which only catheterization was performed.

Conclusions—Patients with coronary artery disease receive more recommendations for PCI and fewer recommendations for CABG surgery than indicated in the American College of Cardiology/American Heart Association guidelines. (***Circulation*. 2010;121:267-275.**)

Key Words: AHA/ACC guidelines ■ procedure indications ■ percutaneous coronary intervention ■ coronary artery bypass surgery

The American College of Cardiology (ACC) and the American Heart Association (AHA) jointly publish guidelines to inform practicing clinicians of the appropriate indications for a variety of treatments, including percutaneous coronary angioplasty (PCI) and coronary artery bypass graft (CABG) surgery[1–3] for patients with coronary artery disease (CAD). These guidelines were created for the purpose of helping clinicians use evidence-based medicine and expert opinions to determine whether the benefits outweigh the risks for these procedures. They include categories in which patients can be placed on the basis of factors such as type of angina, ventricular function, number of coronary vessels diseased, results of noninvasive tests for ischemia, and various other factors.

Editorial see p 194
Clinical Perspective on p 275

Recent studies have examined the conformance with guidelines among patients undergoing PCI[4,5] or CABG surgery[6] and have demonstrated a direct relationship between

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guidelines adherence and better outcomes.[4,5] However, these studies examined conformance to guidelines among patients who received only 1 of the 2 major procedures for CAD and did not examine the concomitant use of PCI and CABG surgery guidelines to make referral choices. This is of particular interest because guidelines exist for both PCI and CABG surgery, and these 2 procedures are competing options for patients with CAD, especially multivessel disease. Furthermore, many of the referring cardiologists who perform the diagnostic procedure that leads to a referral decision (cardiac catheterization) also perform PCI, and PCI is frequently performed during the same catheterization laboratory visit as the cardiac catheterization without seeking a multidisciplinary consultation.

The purpose of the present study was to use a cardiac catheterization database in New York State to compare referral decisions with ACC/AHA guidelines to examine the extent to which cardiac catheterization laboratory cardiologists adhered to guidelines when they were the final source of the recommendation. The study also examined whether adherence rates changed substantially after guidelines were revised by the ACC/AHA and whether adherence to guidelines was impacted by whether the hospital in which the catheterization was performed was certified by the New York State Department of Health to perform PCI and/or CABG surgery.

Methods

Database

Data were obtained from New York State's Cardiac Diagnostic Catheterization Database $(CD)^2$, a voluntary data system in New York maintained by the New York State Department of Health. The data set was developed to capture indications for CABG surgery and PCI with the published ACC/AHA guidelines. These include PCI guidelines published in 2001 and 2005 and CABG surgery guidelines published in 2004.[1–3] Data elements used in the study to identify indications for PCI and CABG surgery were the vessels diseased, including left main disease and proximal left anterior descending coronary artery; Canadian Cardiovascular Society class; whether the anatomy was suitable for PCI and/or surgery; ejection fraction and presence of congestive heart failure; ST-segment elevation myocardial infarction, non–ST-segment elevation myocardial infarction, and unstable angina, if present; diabetes; shock, and hemodynamic instability; area of viable myocardium at risk; and stress test results.

Completeness of data reporting was monitored by matching $(CD)^2$ to New York's acute care hospital discharge database, the Statewide Planning and Research Cooperative System (SPARCS), and New York's PCI Registry (PCIRS, the Percutaneous Coronary Interventions Reporting System) and identifying cases reported with a diagnostic catheterization in those databases that were not reported to $(CD)^2$. Hospitals were required to provide data for those missing cases. In addition, missing or invalid data elements were returned to hospitals for review and correction on an ongoing basis.

With regard to recommendations, the data set indicates whether the catheterization laboratory cardiologist recommended CABG surgery, PCI, medical treatment, or no treatment. The database also indicates whether the final recommendation was anticipated to come from another source (eg, consulting cardiologists or surgeon), but it does not include the final recommendation for those cases.

Patients and Hospitals

A total of 19 hospitals were included in the study. Eight of these hospitals are full-service hospitals that provide PCI and CABG surgery in addition to cardiac catheterization. The other 11 provided only catheterization at the outset of the study, but 5 added PCI during the study. In subsequent analyses that compared types of hospitals, these 5 were classified accordingly in the time frames before and after they added PCI.

Patients in the study included a subset of patients in the 19 study hospitals undergoing cardiac catheterization between January 1, 2005, and December 31, 2007, who had CAD, had not undergone previous revascularization, and were not experiencing an ST-segment elevation myocardial infarction. Patients were excluded if information needed to determine whether a procedure was indicated or should be recommended was missing (n=504), if there were deferred recommendations (n=124) or multiple recommendations (n=872), or if the source of final recommendation was anyone other than the catheterization laboratory cardiologist (n=4813). Recommendations from other sources, deferred recommendation, and multiple recommendations were excluded because the nature of the final recommendation was unknown at the time the data were gathered. Thus, with the exclusion of cases with missing data, there were 16 142 patients who were found to have CAD, and the cardiac catheterization laboratory cardiologist was the final source of recommendation for 10 333 (64%). These patients are the subjects of the present study.

End Points

End points in the study were determinations of whether each patient met the ACC/AHA indications for CABG surgery, PCI, neither, or both and the recommendations made by the catheterization laboratory cardiologist for each patient. The recommendations for each patient were categorized as CABG surgery, PCI, medical treatment, or no treatment.

Statistical Analysis

First, the percentages of patients in each of the 4 categories of indications for the 2 procedures (indicated for PCI and CABG surgery, indicated for PCI only, indicated for CABG surgery only, or indicated for neither procedure) were calculated for each of a variety of patient characteristics (demographics, source of admission, ventricular function, coronary vessel disease, suitability of coronary anatomy for each intervention, presence of angina, previous cardiac procedures, previous myocardial infarction, and several comorbidities). Patients in each of the 4 categories of indications were classified according to whether they were recommended for PCI, CABG surgery, or neither procedure. Percentages of patients who were recommended for each procedure but for whom the procedure was not indicated and percentages of patients who had indications for a procedure but for whom it was not recommended were noted and described. The term "indicated" was first defined in such a way that class I criteria (evidence and/or general agreement that the procedure is effective) and class IIa criteria (the weight of opinion/evidence is in favor of usefulness or efficacy) were treated equally as "adherence to guidelines." If 1 procedure was judged to be class I and the other procedure was judged to be class IIa for a given patient, the patient was said to be indicated for both procedures.

A second set of analyses was then conducted in which meeting class I criteria took precedence over meeting class IIa criteria. That is, if 1 procedure (either CABG surgery or PCI) was judged to be class I and the other procedure (eg, PCI) was judged to be class IIa for a given patient, the patient was said to be indicated for CABG surgery but not for PCI. Subsequent analyses were all variations of the first interpretation of indications, whereby a patient with a class I criterion for 1 procedure and a class IIa criterion for another procedure was regarded as indicated for both procedures.

One supplemental set of analyses compared adherence to guidelines before and after the publication of new PCI guidelines in 2005 to determine whether there was a difference in adherence after the updated guidelines were published. April 1, 2006, was used as the time the new guidelines were incorporated in the present study, to give clinicians time to have read and implemented the 2005 guidelines. The 2004 CABG guidelines were used for the entire time period of the present study for identification of indications for CABG surgery. The analyses described above were repeated for each of the

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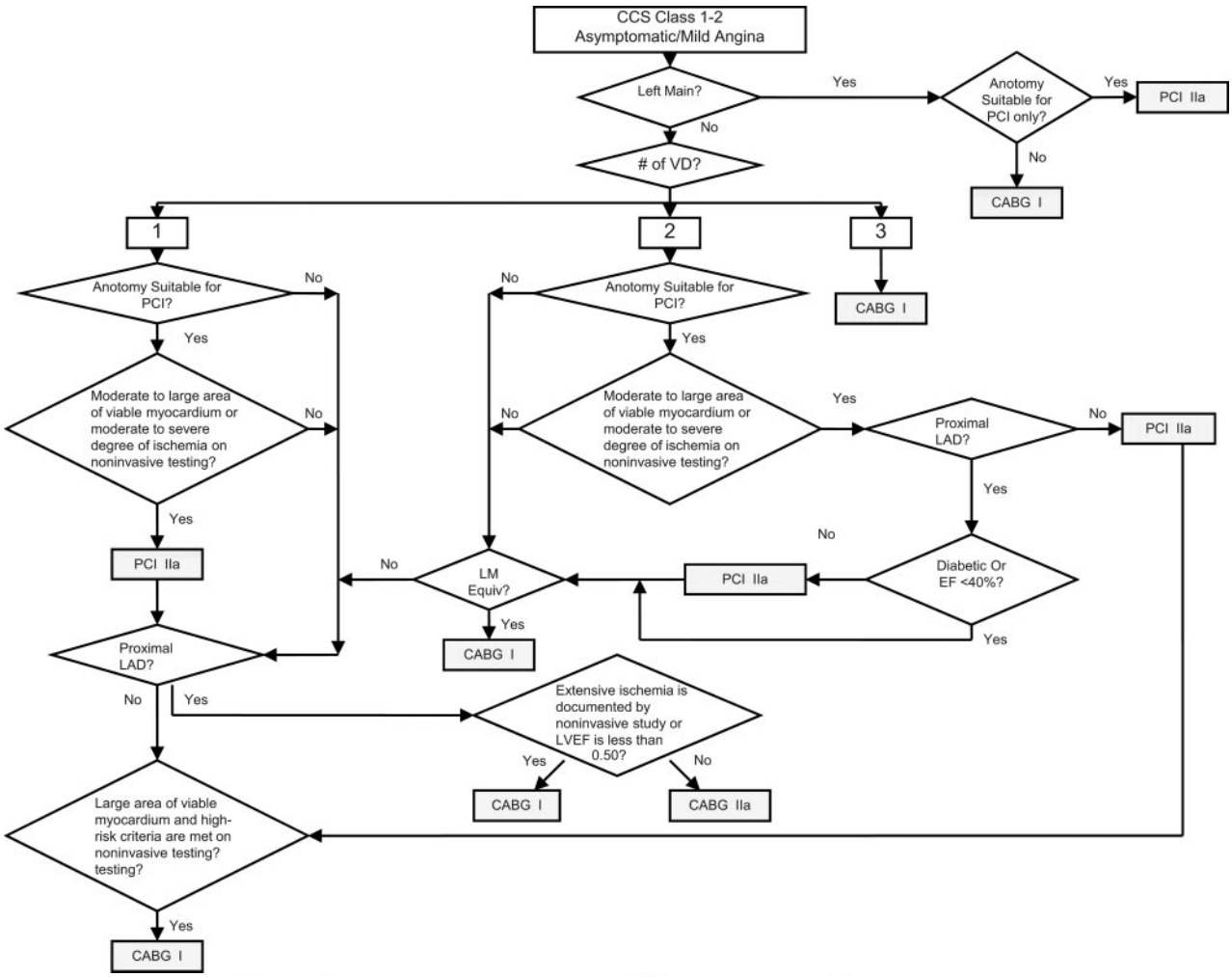

Figure 1. 2005 ACC/AHA indications (class I and IIa) for asymptomatic/mild angina. CCS indicates Canadian Cardiovascular Society; VD, diseased vessels; LAD, left anterior descending coronary artery; LM, left main; EF, ejection fraction; and LVEF, left ventricular ejection fraction.

3 types of hospitals (catheterization-only hospitals that are not certified by the New York State Department of Health to perform PCI, those certified to perform catheterization and elective PCI, and full-service hospitals that are certified to perform both PCI and CABG surgery) to compare their levels of adherence to guidelines.

Results

Flow charts that demonstrate who is indicated for CABG surgery and PCI at levels I and IIa for each of the 3 major groups of patients (asymptomatic/mild angina, stable angina, unstable angina/non–ST-elevation myocardial infarction) in the study are presented in Figures 1 to 3. Of the 16 142 patients undergoing catheterization with complete data who were found to have CAD, the catheterization laboratory cardiologist was the final source of recommendation for 10 333 patients (64%). Of these 10 333 patients, 1337 (12.9%) were indicated for CABG surgery, 6051 (58.6%) were indicated for PCI, 1722 (16.7%) were indicated for CABG surgery and PCI, and 1223 (11.8%) had CAD but were indicated for neither CABG surgery nor PCI (Table 1). A total of 9.6% of the patients were recommended for CABG surgery compared with 77.3% for PCI and 12.7% for medical treatment.

Patients who were indicated for CABG surgery were recommended for it 53% of the time (712 patients). Thirty-four percent of patients (455) with indications for CABG surgery were recommended for PCI, and 12% were recommended for medical therapy. Of the patients with indications for PCI, 94% were recommended for it, 2% were recommended for CABG surgery, and 4% were recommended for medical treatment. For the 17% of patients with indications for both CABG surgery and PCI, 93% were recommended for PCI, 5% were recommended for CABG surgery, and 2% were recommended for medical therapy (Table 1). For the patients with CAD who were not indicated for CABG surgery or PCI (12% of all patients), 71% were recommended for medical treatment, 21% were recommended for PCI, and 6% were recommended for CABG surgery.

Although 53% of the patients with indications for CABG surgery were recommended for CABG, there was a wide variation in the percentage recommended for CABG depending on patients' clinical presentations. In general, CABG was recommended 58% of the time when it was a class I indication (and PCI was indicated at a class below class IIa), but CABG was recommended only 7% of the time when it

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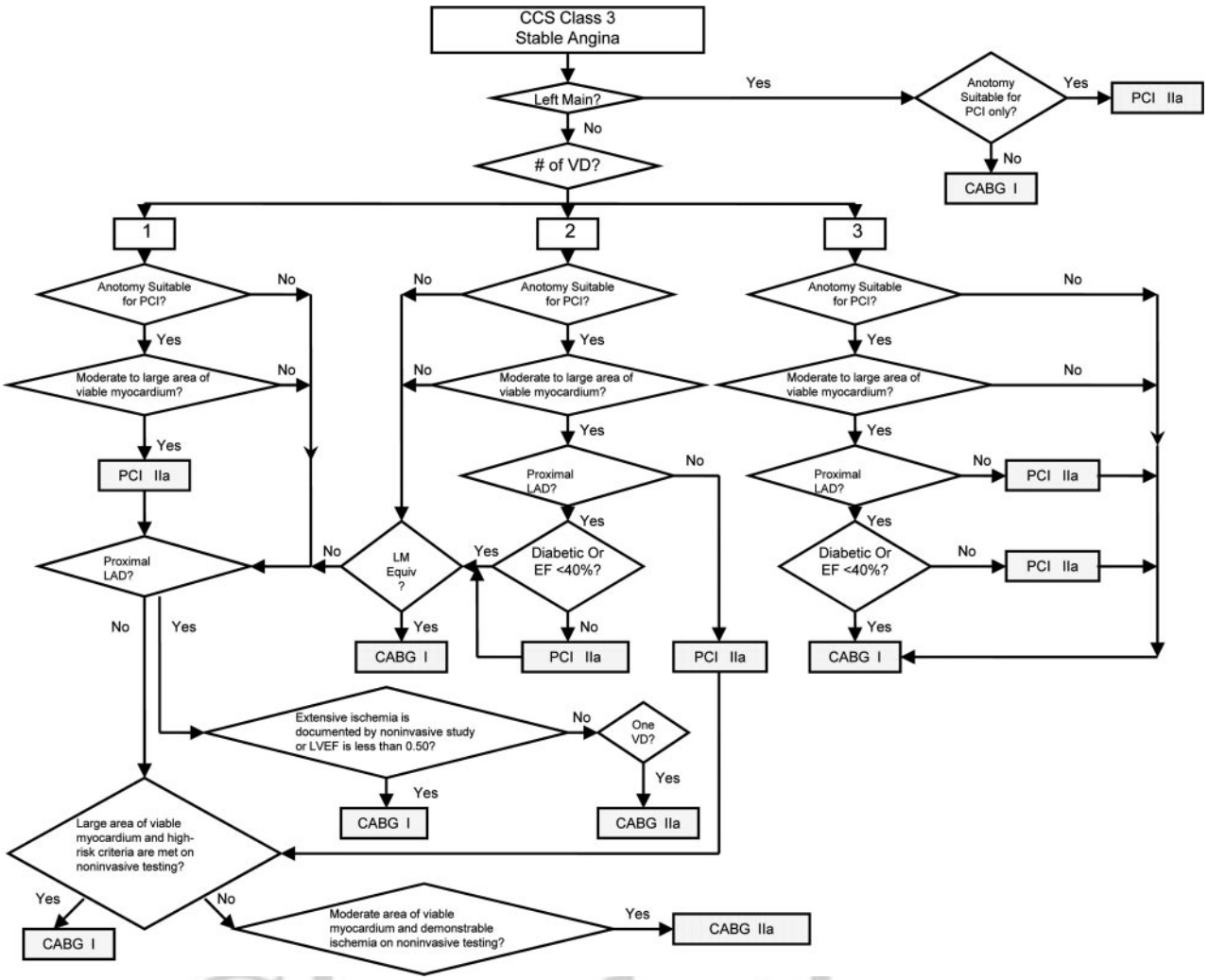

Figure 2. 2005 ACC/AHA indications (class I and IIa) for stable angina. CCS indicates Canadian Cardiovascular Society; VD, diseased vessels; LAD, left anterior descending coronary artery; LM, left main; EF, ejection fraction; and LVEF, left ventricular ejection fraction.

was a class IIa indication (and PCI was indicated at a class below class IIa). The percentage of the time that CABG was recommended for subgroups of CABG-indicated patients was highest at 90% (26 of 29 cases) for patients with stable angina and significant left main disease and 80% (118 of 147) for patients with unstable angina/non–ST-elevation myocardial infarction who had ongoing ischemia, for whom PCI is not optimal or possible. The percentage was lowest at 4% (4 of 96) for patients with unstable angina/non–ST-elevation myocardial infarction who had proximal left anterior descending coronary artery stenosis with 1- or 2-vessel disease.

Table 2 reflects changes in Table 1 when patients who met class I ACC/AHA criteria for 1 procedure and class IIa criteria for the other procedure (invariably CABG and PCI, respectively) were judged as being indicated for the class I procedure. The major change compared with Table 1 was that the percentage of patients indicated only for CABG surgery who were recommended for PCI rose from 34% to 46%, with a concomitant decrease in the percentage of patients indicated only for CABG surgery who were recommended for CABG from 53% to 43%. When the patients in Table 1 (in which class I and class IIa criteria were regarded as equally indicated) were subdivided into 2 groups based on whether the patients underwent cardiac catheterization before or after April 1, 2006 (ie, before or after referring physicians were able to use the 2005 ACC/AHA guidelines), the percentage of patients not indicated for revascularization who were recommended for PCI dropped from 33% to 12% (Table 3).

Table 4 subdivides the results in Table 1 into 3 groups: Patients who underwent cardiac catheterization in hospitals that perform catheterization but no PCI (catheterization-only hospitals), hospitals certified to perform catheterization and elective PCI (elective PCI hospitals), and hospitals certified to perform catheterization, elective PCI, and CABG (full-service PCI hospitals). The percentage of patients who were indicated for CABG who were recommended for PCI rose from 17% in catheterization-only hospitals to 22% in elective PCI hospitals to 43% in full PCI hospitals. These same trends occurred among patients who were indicated for both procedures (a rise in recommendations for PCI from 81% to 85% to 96%). Patients in catheterization-only hospitals appeared to be less sick with regard to angina type (less unstable angina and lower Canadian Cardiovascular Society class), so this was a possible explanation to the extent that nonindicated

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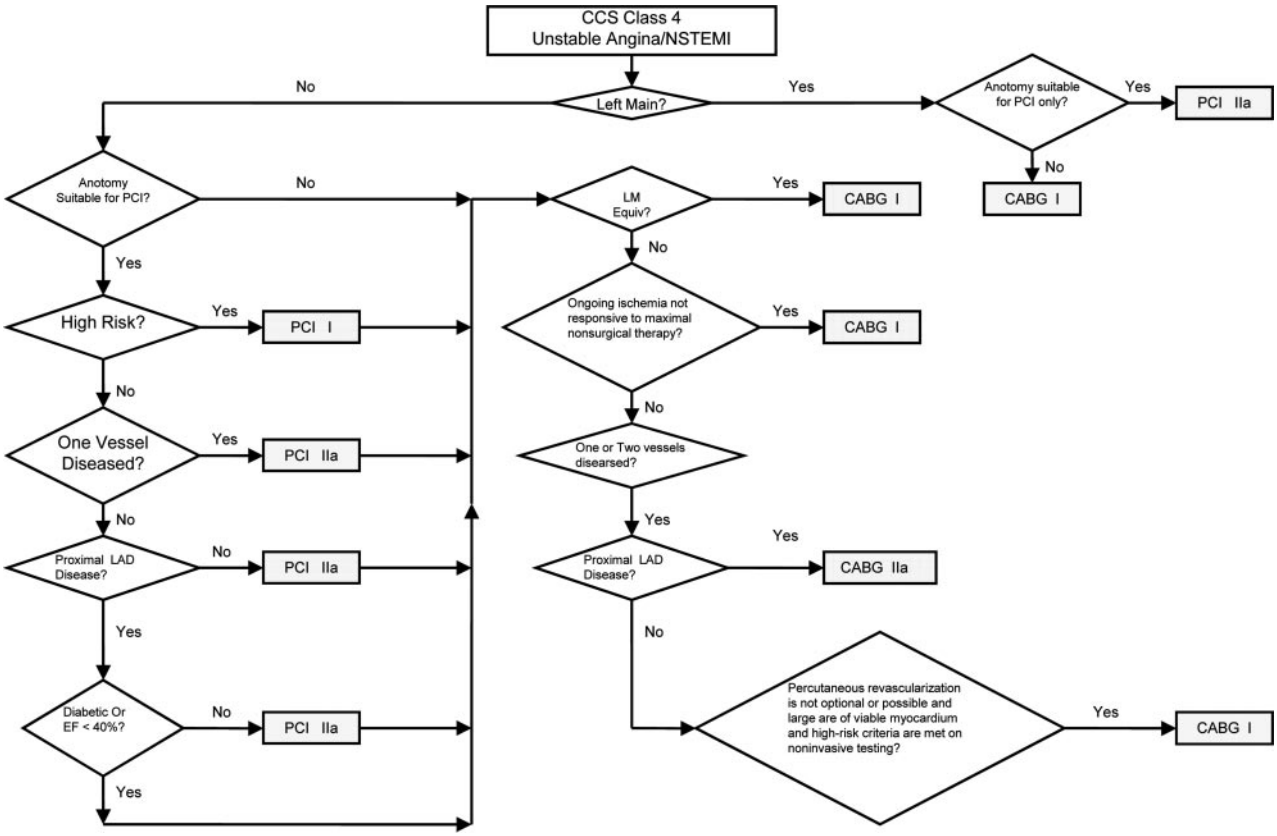

Figure 3. 2005 ACC/AHA indications (class I and IIa) for unstable angina/non–ST-elevation myocardial infarction. CCS indicates Canadian Cardiovascular Society; NSTEMI, non–ST-elevation myocardial infarction; LM, left main; LAD, left anterior descending coronary artery; and EF, ejection fraction.

patients were recommended disproportionately for different clinical presentations.

The variation in the percentage of patients in individual hospitals who were indicated for CABG but recommended for PCI was quite wide, with a range from 4% to 91% among hospitals with at least 50 patients indicated for CABG. However, the mean of 34% in Table 1 was not driven by a few large hospitals.

For all but 2 hospitals, the percentage of patients indicated for both CABG and PCI who were recommended for PCI was >80%. For those 2 hospitals, 57% (74 of 129) and 63% (30 of 48) of such patients were recommended for PCI.

Of the 7984 patients recommended for PCI, 6941 patients were in hospitals with PCI capability. A total of 6399 (92.2%) of these patients underwent ad hoc PCI (PCI in the same catheterization laboratory visit as their cardiac catheterization).

Discussion

The ACC and the AHA periodically have developed guidelines for the use of CABG surgery and PCI for patients with coronary heart disease. Surprisingly few studies have been conducted to determine the extent to which referring physicians use these guidelines or any guidelines in clinical practice. Anderson et al[5] used data from the ACC's National Cardiovascular Data Registry from January 2001 to March 2004 to demonstrate that 64% of the PCI patients were class I, 21% were class IIa, 7% were class IIb, and 8% were class III. In addition, clinical success (<25% residual stenosis without myocardial infarction, same-admission CABG surgery, or death) rates were directly related to indication class and varied from 92.8% for class I to 85.5% for class III.[5]

O'Connor et al[6] used data from the Northern New England Cardiovascular Disease Study Group to determine the con-

Table 1. ACC/AHA Indications vs Catheterization Laboratory Recommendations, New York, January 1, 2005–December 31, 2007: Indications for ACC/AHA Class I and Class IIa Regarded as Equal

ACC/AHA Indication/Cath Lab Recommendation	CABG, n (%)	PCI, n (%)	Medical Treatment, n (%)	None, n (%)	Total, n (%)
CABG	712 (53)	455 (34)	156 (12)	14 (1)	1337 (100)
PCI	124 (2)	5660 (94)	255 (4)	12 (<1)	6051 (100)
CABG and PCI	84 (5)	1608 (93)	26 (2)	4 (<1)	1722 (100)
Neither CABG or PCI	70 (6)	261 (21)	873 (71)	19 (2)	1223 (100)
Total	990 (10)	7984 (77)	1310 (13)	49 (<1)	10 333 (100)

Cath Lab indicates catheterization laboratory.

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Table 2. ACC/AHA Indications vs Catheterization Laboratory Recommendations, New York, January 1, 2005–December 31, 2007: Indications for Class I for 1 Procedure Regarded as Superior to Indications for Class IIa for Another Procedure

ACC/AHA Indication/Cath Lab Recommendation	CABG, n (%)	PCI, n (%)	Medical Treatment, n (%)	None, n (%)	Total, n (%)
CABG	748 (43)	800 (46)	160 (9)	15 (1)	1723 (100)
PCI	132 (2)	6086 (94)	259 (4)	14 (<1)	6491 (100)
CABG and PCI	40 (4)	837 (93)	18 (2)	1 (<1)	896 (100)
Neither CABG or PCI	70 (6)	261 (21)	873 (71)	19 (2)	1223 (100)
Total	990 (10)	7984 (77)	1310 (13)	49 (<1)	10 333 (100)

Cath Lab indicates catheterization laboratory.

cordance of patients undergoing CABG surgery in northern New England with the 2004 ACC/AHA guideline update for CABG surgery.[3] They found that 87.7% of the procedures performed were class I, 8.4% were class IIa, 2.5% were class IIb, and 1.4% were class III.

Guidelines other than those developed by the ACC/AHA were used in a few earlier studies. Leape et al[7] used guidelines developed by RAND[8] to examine the appropriateness of use of CABG surgery in New York State in 1990. They concluded that nearly 91% of the procedures were appropriate, 7% were uncertain, and 2.4% were inappropriate.[7] McGlynn et al[9] demonstrated that the rates of inappropriateness of coronary angiography and CABG surgery were low in both Canada and New York State. Hilborne et al[10] used RAND criteria to conclude that in New York State in 1990, 58% of percutaneous transluminal coronary angioplasty (PTCA, the previous term for PCI) cases were appropriate, with 38% uncertain and 4% inappropriate.

Although most studies have examined the overuse of cardiac procedures, some studies have examined underuse by applying RAND appropriateness criteria for coronary angiography to determine the percentages of those patients who received indicated procedures. Hannan et al[11] found that 52% of angiography patients for whom CABG surgery was found to be appropriate received it within 3 months, and there were significant differences by race. Leape et al[12] found that 74% of patients in New York City in 1992 who met the RAND appropriateness criteria for revascularization received either CABG surgery or PTCA (PCI).

Most of the studies referenced above are relatively old; all but 2 used now-outdated RAND criteria rather than ACC/AHA criteria; none looked at both potential overuse and underuse of procedures; and none looked at the interface of CABG surgery and PCI with regard to whether 1 of the 2 procedures was used or recommended when the other was indicated by guidelines. This last point is particularly important, because many recent studies have examined outcomes according to choice of revascularization. These studies include studies that compared drug-eluting and bare-metal stents.[13–15] Other studies have compared outcomes for CABG surgery and PCI and generally have found CABG surgery outcomes to be superior.[16–18] Furthermore, some recent studies have compared medical treatment favorably with PCI for patients with stable coronary disease.[19,20] In light of all of these recent findings, it is important to determine who is being referred for various treatment options and to learn how

Table 3. A. ACC/AHA Indications vs Catheterization Laboratory Recommendations, New York, January 1, 2005–March 31, 2006 and April 1, 2006–December 31, 2007*

ACC/AHA Indication/Cath Lab Recommendation	CABG, n (%)	PCI, n (%)	Medical Treatment, n (%)	None, n (%)	Total, n (%)
January 1, 2005–March 31, 2006					
CABG	191 (45)	186 (43)	48 (11)	4 (1)	429 (100)
PCI	28 (1)	2056 (94)	92 (4)	4 (<1)	2180 (100)
CABG and PCI	27 (4)	609 (93)	15 (2)	3 (<1)	654 (100)
Neither CABG or PCI	36 (7)	181 (33)	322 (59)	9 (2)	548 (100)
Total	282 (7)	3032 (80)	477 (13)	20 (1)	3811 (100)
April 1, 2006–December 31, 2007					
CABG	521 (57)	269 (30)	108 (12)	10 (1)	908 (100)
PCI	96 (2)	3604 (93)	163 (4)	8 (<1)	3871 (100)
CABG and PCI	57 (5)	999 (94)	11 (1)	1 (<1)	1068 (100)
Neither CABG or PCI	34 (5)	80 (12)	551 (82)	10 (1)	675 (100)
Total	708 (11)	4952 (76)	833 (13)	29 (<1)	6522 (100)

Cath Lab indicates catheterization laboratory.

The period from April 1, 2006, through December 31, 2007, represents the period during which referring physicians were able to use the 2005 ACC/AHA guidelines in determining which procedure was appropriate.

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Table 4. ACC/AHA Indications vs Catheterization Laboratory Recommendations, New York, January 1, 2005–December 31, 2007

ACC/AHA Indication/Cath Lab Recommendation	CABG, n (%)	PCI, n (%)	Medical Treatment, n (%)	None, n (%)	Total, n (%)
Hospitals with cath labs but no PCI					
CABG	226 (73)	52 (17)	25 (8)	5 (2)	308 (100)
PCI	39 (4)	787 (86)	85 (9)	7 (1)	918 (100)
CABG and PCI	30 (14)	168 (81)	9 (4)	1 (<1)	208 (100)
Neither CABG or PCI	46 (22)	36 (17)	126 (60)	1 (<1)	209 (100)
Total	341 (21)	1043 (63)	245 (15)	14 (1)	1643 (100)
Hospitals with cath labs and PCI but no cardiac surgery privileges					
CABG	130 (67)	42 (22)	18 (9)	3 (2)	193 (100)
PCI	45 (6)	650 (89)	36 (5)	0 (0)	731 (100)
CABG and PCI	24 (13)	152 (85)	3 (2)	0 (0)	179 (100)
Neither CABG or PCI	5 (9)	6 (11)	43 (77)	2 (4)	56 (100)
Total	204 (18)	850 (73)	100 (9)	5 (<1)	1159 (100)
Hospitals with catheterization laboratories and PCI/CABG (full-service hospitals)					
CABG	356 (43)	361 (43)	113 (14)	6 (1)	836 (100)
PCI	40 (1)	4223 (96)	134 (3)	5 (<1)	4402 (100)
CABG and PCI	30 (2)	1288 (96)	14 (1)	3 (<1)	1335 (100)
Neither CABG or PCI	19 (2)	219 (23)	704 (73)	16 (2)	958 (100)
Total	445 (6)	6091 (81)	965 (13)	30 (<1)	7531 (100)

Cath Lab indicates catheterization laboratory.

these referral patterns compare with the latest ACC/AHA guidelines and the latest studies that compare outcomes for competing interventions.

The present study demonstrates that for 64% of patients undergoing catheterization who were found to have CAD, the source of the final recommendations for treatment was the cardiac catheterization laboratory cardiologist. Of the subset of these patients who were indicated for CABG surgery, 53% were recommended for CABG and 34% for PCI. Of the patients indicated for PCI, 94% were recommended for PCI. For the patients who were indicated for both CABG surgery and PCI, 93% were recommended for PCI and 5% for CABG surgery.

Thus, patients received more recommendations for PCI and fewer for CABG surgery than were indicated. The tendency to recommend PCI for patients who were either indicated for CABG surgery or indicated for both procedures was more accentuated in hospitals with PCI capability. In summary, these findings suggest that catheterization laboratory cardiologists make final recommendations relatively frequently and that these recommendations are frequently for PCI despite the fact that CABG surgery or both CABG and PCI are indicated. The finding that PCI appears to be recommended more often than indicated is particularly important because as noted above, some recent studies have found CABG surgery outcomes to be better than PCI outcomes for patients with multivessel disease,[16–18] and other studies have found that medical treatment compares favorably with PCI for patients with stable coronary disease.[19,20]

There are a few caveats to the present study. First, we had to translate the ACC/AHA indications for CABG and PCI into a flowchart that incorporates both of them simultaneously, and there may be disagreement on the way this was done. For instance, we developed indications by taking the ACC/AHA guidelines in the order in which they were presented for each level, and different interpretations could result if the order were changed. In addition, we did not have access to information relative to whether the patient was already receiving medical therapy, which was a factor in defining some indications. Indications for PCI would be reduced if the patient was not undergoing medical therapy, so the impact of having this data element would be to increase the number of recommendations for PCI among patients for whom it was not indicated. However, it would have been valuable to have had information on the extent of medical therapy in the study.

Nonetheless, we believe our interpretations are essentially the same as those made in recent studies,[4,6] and we have developed the flow charts presented in the appendices so that the logic is transparent. We believe these flowcharts are the first attempt to integrate ACC/AHA indications for both CABG surgery and PCI, and we are hopeful they can be used as a first cut for revision or by referring physicians to determine potential indications for patients with CAD.

Recent commentary on ACC/AHA clinical practice guidelines reminds us that clinical practice guidelines are intended to be only general guides for practice, and there may be extenuating circumstances that may lead a provider or patient to opt for a different decision.[21] In addition, the CABG and PCI guidelines were developed at different times, by different people, in different ways, and no effort appears to have been

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made to standardize them so referring physicians could use them simultaneously to make recommendations. Consequently, another major reason for the lack of concordance between guidelines and recommendations may be that referring physicians were unable to determine what should have been recommended according to the guidelines. The ACC and AHA in conjunction with other professional organizations have recently published appropriateness criteria for coronary revascularization that were developed to serve as a supplement to the ACC/AHA guideline documents.[22] Although that document does not distinguish between appropriateness of PCI and CABG surgery for all patients (because for some groups, the appropriateness rating applies only to "revascularization"), it does address the appropriateness of both procedures in the same document, and it would be interesting to apply the methodology used in the present study to these new appropriateness criteria.

Furthermore, the results may not be representative of all patients undergoing cardiac catheterization in New York. A total of 19 of the 75 to 80 hospitals that provided cardiac catheterization in New York volunteered to be part of the study. For 2005, the earliest year of the study, there were 10 hospitals in the study, and hospitals were gradually added until all 19 were participating. Over the course of the study period, 5 catheterization-only hospitals began providing elective PCI, and these hospitals were treated in the analyses according to their status at the time.

We did not always know whether the treatment that was recommended was actually received. However, we were able to determine whether patients recommended by the catheterization laboratory cardiologist for PCI in a hospital with PCI capability underwent ad hoc PCI (PCI in the same laboratory visit as the cardiac catheterization). As noted in the Results, most patients recommended for PCI in the present study (6941 of 7984) were in hospitals with PCI capability, and more than 92% of these patients underwent ad hoc PCI. This demonstrates that patients recommended for PCI did receive the procedure, and they received it with seemingly little multidisciplinary input or deliberation.

Although an examination of the patients recommended for medical therapy who were indicated for revascularization provides some measure of underuse of revascularization procedures, it is likely that because cardiac catheterization is the driver for revascularization procedures, the majority of underuse would be among patients who never received cardiac catheterization. In conclusion, the results of the present study suggest that multidisciplinary input before final treatment recommendations should be promoted to improve concordance with professional guidelines.

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Disclosures

None.

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CLINICAL PERSPECTIVE

Although the American College of Cardiology and the American Heart Association have issued guidelines for the use of coronary artery bypass graft surgery (CABG) and percutaneous coronary interventions (PCI) for many years, little is known about the impact of these evidence-based guidelines on referral decisions. A cardiac catheterization laboratory database used by 19 hospitals in New York State was used to identify treatment (CABG surgery, PCI, medical treatment, or nothing) recommended by the catheterization laboratory cardiologist for patients undergoing catheterization with asymptomatic/mild angina, stable angina, and unstable angina/non–ST-elevation myocardial infarction between January 1, 2005, and August 31, 2007. The recommended treatment was compared with indications for these patients based on American College of Cardiology/American Heart Association guidelines. Findings were that of the 16 142 patients undergoing catheterization who were found to have coronary artery disease, the catheterization laboratory cardiologist was the final source of recommendation for 10 333 patients (64%). Of these cases, 13% were indicated for CABG surgery, 59% for PCI, and 17% for CABG surgery and PCI. Of the patients who were indicated for CABG surgery, 53% were recommended for CABG and 34% for PCI. Of the patients indicated for PCI, 94% were recommended for PCI. For the patients who were indicated for both CABG surgery and PCI, 93% were recommended for PCI and 5% for CABG surgery. In conclusion, patients with coronary artery disease receive more recommendations for PCI and fewer recommendations for CABG surgery than are indicated in the American College of Cardiology/American Heart Association guidelines.

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ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 Appropriate Use Criteria for Coronary Revascularization Focused Update

American College of Cardiology Foundation Appropriate Use Criteria Task Force, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, American Association for Thoracic Surgery, American Heart Association, American Society of Nuclear Cardiology, Society of Cardiovascular Computed Tomography, American Society of Echocardiography, Heart Rhythm Society, Manesh R. Patel, Gregory J. Dehmer, John W. Hirshfeld, Peter K. Smith, and John A. Spertus

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APPROPRIATE USE CRITERIA

ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 Appropriate Use Criteria for Coronary Revascularization Focused Update

A Report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, American Association for Thoracic Surgery, American Heart Association, American Society of Nuclear Cardiology, and the Society of Cardiovascular Computed Tomography

Endorsed by the American Society of Echocardiography and the Heart Rhythm Society

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Abstract

The American College of Cardiology Foundation (ACCF), Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, and the American Association for Thoracic Surgery, along with key specialty and subspecialty societies, conducted an update of the appropriate use criteria (AUC) for coronary revascularization frequently considered. In the initial document, 180 clinical scenarios were developed to mimic patient presentations encountered in everyday practice and included information on symptom status, extent of medical therapy, risk level as assessed by noninvasive testing, and coronary anatomy. This update provides a reassessment of clinical scenarios the writing group felt to be affected by significant changes in the medical literature or gaps from prior criteria. The methodology used in this update is similar to the initial document, and the definition of appropriateness was unchanged. The technical panel scored the clinical scenarios on a scale of 1 to 9. Scores of 7 to 9 indicate that revascularization is considered appropriate and likely to improve patients' health outcomes or survival. Scores of 1 to 3 indicate revascularization is

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considered inappropriate and unlikely to improve health outcomes or survival. Scores in the mid-range (4 to 6) indicate a clinical scenario for which the likelihood that coronary revascularization will improve health outcomes or survival is uncertain.

In general, as seen with the prior AUC, the use of coronary revascularization for patients with acute coronary syndromes and combinations of significant symptoms and/or ischemia is appropriate. In contrast, revascularization of asymptomatic patients or patients with low-risk findings on noninvasive testing and minimal medical therapy are viewed less favorably. The technical panel felt that based on recent studies, coronary artery bypass grafting remains an appropriate method of revascularization for patients with high burden of coronary artery disease (CAD). Additionally, percutaneous coronary intervention may have a role in revascularization of patients with high burden of CAD. The primary objective of the appropriate use criteria is to improve physician decision making and patient education regarding expected benefits from revascularization and to guide future research.

Preface

The American College of Cardiology Foundation (ACCF), in collaboration with the Society for Cardiovascular Angiography and Interventions (SCAI), the Society of Thoracic Surgeons (STS), the American Association for Thoracic Surgery (AATS), and other societies, developed and published in 2009 appropriate use criteria (AUC) for certain clinical scenarios in which coronary revascularization could be used in an effort to address the rational use of coronary revascularization in the delivery of high-quality care. This document is the first focused update of the original document and includes new literature published since the original document and gaps noted during implementation.

The publication of AUC reflects one of several ongoing efforts by the ACCF and its partners to assist clinicians caring for patients with cardiovascular diseases and in support of high-quality cardiovascular care. The ACCF/American Heart Association (AHA) clinical practice guidelines provide a foundation for summarizing evidence-based cardiovascular care and, when evidence is lacking, provide expert consensus opinion that is approved in review by the ACCF and AHA. However, in many areas, variability remains in the use of cardiovascular procedures, raising questions of over- or underuse. The AUC provide a practical standard upon which to assess and better understand variability.

We are grateful to the technical panel and its chair, Frederick A. Masoudi, MD, MSPH, FACC, FAHA, a professional group with a wide range of skills and insights, for their thoughtful and thorough deliberation of the merits of coronary revascularization for various clinical scenarios. We would also like to thank the parent AUC Task Force and the ACCF staff, Joseph M. Allen and Lea Binder, for their exceptionally skilled support in the generation of this document.

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Introduction

This report is a focused update of the AUC for coronary revascularization published in 2009 (1). The increasing prevalence of coronary artery disease (CAD), continued advances in surgical and percutaneous techniques for revascularization and concomitant medical therapy for CAD, and the costs of revascularization have resulted in heightened interest regarding the appropriate use of coronary revascularization. Clinicians, payers, and patients are interested in the specific benefits of revascularization. Inappropriate revascularization may be harmful to patients and generate unwarranted costs to the healthcare system, whereas appropriate revascularization procedures can improve patients' clinical outcomes.

As in the original AUC document, the same classification scheme with ratings of appropriate, uncertain, and inappropriate was used. The uncertain category can cause confusion in the interpretation of the AUC and can imply several meanings within its definition. First, the rating of uncertain is used when pertinent literature is either not available or when true discrepancies exist. Second, it is impossible to include every relevant piece of clinical information (e.g., age, sex, diabetes) in the individual clinical scenarios. Attempting to do that may result in an unmanageable number of clinical scenarios and thus compromise the usefulness of the AUC in daily practice. The practice of medicine is full of uncertainties that require a thoughtful clinician to use his or her best judgment about each patient to reach decisions about management. Therefore, a rating of uncertain may be assigned by members of the technical panel if clinical information not provided might affect their individual rating, causing a shift into either the appropriate or inappropriate category.

A rating of uncertain means simply what the name implies, and depending on additional factors, it can be appropriate or inappropriate to perform revascularization. The writing group emphasizes that uncertain indications are not inappropriate. Rather, they reflect clinical scenarios that are reasonable for performing revascularization, but additional clinical factors should be considered or further research is needed to more definitively define the benefits of treatment for patients.

All prior AUC publications have reflected an ongoing effort to critically and systematically create, review, and categorize the appropriateness of certain cardiovascular

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diagnostic tests, whereas the AUC for coronary revascularization remains the only document addressing treatment. The writing group and technical panel members for this update are identical to the initial AUC (with only 1 exception) and comprised of members from relevant professional societies including both practicing interventional cardiologists and a cardiothoracic surgeon.

For the majority of clinical scenarios, the technical panel only considered the appropriate use of revascularization irrespective of whether this was accomplished by percutaneous coronary intervention (PCI) or coronary artery bypass graft surgery (CABG). However, in a select subgroup of clinical scenarios in which revascularization is generally considered appropriate, the appropriateness of PCI and CABG, individually, was considered. In this subgroup, it was recognized that a focused update could be necessary following publication of the SYNTAX (Synergy Between PCI With TAXUS and Cardiac Surgery) trial (2). Therefore, in this update, the writing group identified 4 indications possibly affected by results of the SYNTAX trial for reexamination. The writing group also split 2 of the indications to represent levels of disease burden, recognizing, however, that the ability to reproducibly quantify the SYNTAX score in routine clinical practice has challenges. Also in this subgroup, the variables of diabetes and depressed left ventricular function were included in the initial AUC, but these were combined for the update because all indications with these variables were rated the same in the previous scores by the technical panel.

In addition, since the publication of the original document, efforts to implement data collection protocols related to the AUC indications identified a gap in the clinical scenarios related to lower-risk unstable angina/non–ST-segment elevation myocardial infarction (UA/NSTEMI) patients and asymptomatic patients with 1- or 2-vessel CAD not involving the proximal left anterior descending artery (LAD) in whom no noninvasive testing had been performed. Although limited new evidence is available for these patient populations since publication, the writing group developed indications to address these previous omissions.

Methods

A detailed description of the methods used for rating the selected clinical indications is found in a previous publication, "ACCF Proposed Method for Evaluating the Appropriateness of Cardiovascular Imaging" (3). Briefly, this process combines evidence-based medicine and practice experience by engaging a technical panel in a modified Delphi exercise. The technical panel is created from nominations given by multiple relevant professional societies and provider-led organizations as well as from health policy and payer communities. To preserve objectivity, technical panels are created so as to not include a majority of individuals whose livelihood is tied to the technology under evaluation.

In making its appropriate use determinations, the technical panel is provided with summaries of the relevant evidence from the medical literature and practice guidelines. Panelists are first asked individually, and then collectively, to assess the benefits and risks of a test or procedure in the context of the potential benefits to patients' outcomes and an implicit understanding of the associated resource use and costs. After the rating process, the final appropriate use ratings are summarized using an established rigorous methodology (4).

Indication Development

Appropriate use criteria are based on current understanding of the technical capabilities and potential patient benefits of the procedures examined. The AUC are also developed to identify common clinical scenarios—but they cannot possibly include every conceivable patient presentation. The term *indication* is used interchangeably with *clinical scenario* in the document for brevity and does not imply that a procedure should necessarily be performed. Some patients seen in clinical practice are not represented in these appropriate use criteria or have additional extenuating features that would alter the appropriateness of treatment as compared with the clinical scenarios presented. Additionally, although AUC indications and ratings are shaped by the guidelines, the AUC often contain more detailed clinical scenarios than the more generalized situations covered in clinical practice guidelines, and thus, subtle differences between these 2 guidance tools may be possible. To minimize this possibility, the coronary revascularization criteria were updated in conjunction with members of the ACCF/AHA PCI and CABG revascularization guideline committees.

Appropriate use criteria are intended to assist patients and clinicians, but are not intended to diminish the acknowledged difficulty or uncertainty of clinical decision making and cannot act as substitutes for sound clinical judgment and practice experience. Rather, the aim of these criteria is to allow assessment of utilization patterns for a test or procedure. Comparing utilization patterns across a large subset of provider's patients can allow for an assessment of a provider's management strategies with those of his/her peers. The ACCF and its collaborators believe that an ongoing review of one's practice using these criteria will help guide a more effective, efficient, and equitable allocation of healthcare resources, and ultimately, better patient outcomes.

The indications went through external review by multisociety and specialty representation for the 2009 document. Because of the narrow focus, the indications were not sent for external review for this update.

Scope of Indications

As previously described, the indications for coronary revascularization were developed considering the following common variables:

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a. The clinical presentation (e.g., acute coronary syndrome, stable angina);
b. Severity of angina (asymptomatic, Canadian Cardiovascular Society [CCS] Class I, II, III, or IV);
c. Extent of ischemia on noninvasive testing and the presence or absence of other prognostic factors, such as congestive heart failure, depressed left ventricular function, or diabetes;
d. Extent of medical therapy; and
e. Extent of anatomic disease (1-, 2-, 3-vessel disease, with or without proximal LAD or left main coronary disease).

The clinical scenarios developed include coronary anatomy, as this is the focus of much of the previous literature on coronary revascularization. However, the writing group recognizes that for everyday patient care, symptom status, ischemic burden, and level of medical therapy often play a critical role in decision making even before the coronary anatomy has been defined by angiography. It is important to note that the indications focus on revascularization, percutaneous or surgical, and do not address diagnostic catheterization or coronary angiography; these criteria are currently under development.

Technical Panel Selection

Stakeholders were given the opportunity to participate in the AUC process by submitting nominees from their organizations through a call for nominations announced in the summer of 2006. From this list of nominees, the AUC Task Force and writing group selected technical panel members to ensure an appropriate balance with respect to expertise. The 17-member technical panel was composed of 4 interventional cardiologists, 4 cardiovascular surgeons, 8 members representing noninterventional cardiologists, other physicians who treat patients with cardiovascular disease, health outcome researchers, and 1 medical officer from a health plan. For the update of the AUC for coronary revascularization, the same technical panelists (with 1 exception) from the original document published in 2009 were reconvened to rerate the 15 clinical scenarios included in the focused update.

Rating Process and Scoring

The technical panel members first rated indications independently. Then, the technical panel participated in 2 conferences calls for a discussion of each indication. After the discussion, panelists independently provided their final scores for each indication. Each panelist had equal weight in producing the final result for the indications and was not forced into consensus. For each indication, the median numerical score was determined and then assigned to an appropriate use category.

For the conference calls, each technical panelist received a personalized rating form that indicated his/her rating for each indication and the distribution of de-identified ratings of other members of the panel. In addition, the moderator received a summary rating form with similar information (including panelist identification), along with other statistics reflecting the level of agreement among technical panel members. The level of agreement among panelists, as defined by RAND, was analyzed for each indication based on the BIOMED rule for a panel of 14 to 16 (a simplified RAND method for determining disagreement) (4). Per the BIOMED definition, agreement was defined as an indication where 4 or fewer panelists' ratings fell outside the 3-point region containing the median score. Disagreement was defined as a situation where at least 5 panelists' ratings fell in both the appropriate and the inappropriate categories. Because the technical panel had 17 representatives, which exceeded the 16 addressed in this rule, an additional level of agreement analysis as described by RAND was performed that examined the interpercentile range compared with interpercentile range adjusted for symmetry (4). This information was used by the moderator to guide the technical panel's discussion by highlighting areas of differences among the panelists.

In developing these appropriate use criteria for coronary revascularization, the technical panel was asked to assess whether coronary revascularization for each indication was appropriate, uncertain, or inappropriate using the following definition of appropriate use:

Coronary revascularization is appropriate when the expected benefits, in terms of survival or health outcomes (symptoms, functional status, and/or quality of life) exceed the expected negative consequences of the procedure.

The technical panel scored each indication on a scale from 1 to 9 as follows:

Median Score 7 to 9

Appropriate procedure for specific indication (procedure **is** generally acceptable and **is** a reasonable approach for the indication).

Median Score 4 to 6

Uncertain for specific indication (procedure **may** be generally acceptable and **may** be a reasonable approach for the indication). Uncertainty implies that more research and/or patient information is needed to classify the indication definitively.

Median Score 1 to 3

Inappropriate procedure for that indication (procedure **is not** generally acceptable and **is not** a reasonable approach for the indication).

The division of these scores into 3 levels of appropriateness is somewhat arbitrary, and the numeric designations should be viewed as a continuum. Further, there is diversity in clinical opinion for particular clinical scenarios, such that scores in the intermediate level of appropriateness should be labeled uncertain, because critical patient or research data may be lacking or discordant. This designation serves as a prompt to the field to carry out definitive research investigations whenever possible. It is anticipated that the AUC reports will continue to be revised as further data are

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generated and information from the implementation of the criteria is accumulated.

To prevent bias in the scoring process, care was taken in providing objective, nonbiased information, including guidelines and key references, to the technical panel.

General Assumptions

Specific assumptions are provided that were considered by the technical panel in rating the relevant clinical scenarios for the appropriate use of revascularization:

1. Each clinical scenario includes the patient's clinical status/symptom complex, ischemic burden by noninvasive functional testing when presented, burden of coronary atherosclerosis as determined by angiography, and intensity of medical therapy in the determination of the appropriate use of coronary revascularization.
2. Assume coronary angiography has been performed when these findings are presented in the indications. The technical panel should rate the appropriateness of revascularization based upon the clinical features and coronary findings, and not the appropriateness of diagnostic coronary angiography.
3. Assume left main coronary artery stenosis (greater than or equal to 50% luminal diameter narrowing) or proximal LAD stenosis (greater than or equal to 70% luminal diameter narrowing) is not present unless specifically noted. Assume no other significant coronary artery stenoses are present except those noted in the clinical scenario.
4. The clinical scenarios should be rated based on the published literature regarding the risks and benefits of percutaneous and surgical coronary revascularization. Note that specific patient groups not well represented in the literature are not presented in the current clinical scenarios. However, the writing group recognizes that decisions about coronary artery revascularization in such patients are frequently required. Examples of such patients include those with end-stage renal disease or advanced age.
5. Clinical outcome is related to the extent of coronary artery disease (Table A1) (5). Based on this observation and clinical guideline recommendations regarding "borderline" angiographic stenosis (50% to 60%) in epicardial (non-left main) locations, a significant coronary stenosis for the purpose of the clinical scenarios is defined as:
   - Greater than or equal to 70% luminal diameter narrowing, by visual assessment, of an epicardial stenosis measured in the "worst view" angiographic projection.
   - Greater than or equal to 50% luminal diameter narrowing, by visual assessment, of a left main stenosis measured in the "worst view" angiographic projection.

Table A1. CAD Prognostic Index

Extent of CAD	Prognostic Weight (0–100)	5-Year Survival Rate (%)*
1-vessel disease, 75%	23	93
>1-vessel disease, 50% to 74%	23	93
1-vessel disease, ≥95%	32	91
2-vessel disease	37	88
2-vessel disease, both ≥95%	42	86
1-vessel disease, ≥95% proximal LAD	48	83
2-vessel disease, ≥95% LAD	48	83
2-vessel disease, ≥95% proximal LAD	56	79
3-vessel disease	56	79
3-vessel disease, ≥95% in at least 1	63	73
3-vessel disease, 75% proximal LAD	67	67
3-vessel disease, ≥95% proximal LAD	74	59

*Assuming medical treatment only. Reprinted with permission from Califf et al. (5).
CAD = coronary artery disease; LAD = left anterior descending coronary artery.

6. All patients are receiving standard care, including guideline-based risk factor modification for primary or secondary prevention in cardiovascular patients unless specifically noted (6–10).
7. Despite the best efforts of the clinician, all patients may not achieve target goals for risk factor modification. However, a plan of care to address risk factors is assumed to be occurring in patients represented in the indications. For patients with chronic stable angina, the writing group recognizes that there is a wide variance in the medical therapy for angina. The specific definition of maximal anti-ischemic medical therapy is presented in the definition section and includes the use of 2 or more antianginal medications.
8. Operators performing percutaneous or surgical revascularization have appropriate clinical training and experience and have satisfactory outcomes as assessed by quality assurance monitoring (11–13).
9. Revascularization by either percutaneous or surgical methods is performed in a manner consistent with established standards of care (11–13).
10. In the clinical scenarios, no unusual extenuating circumstances exist (such as inability to comply with antiplatelet agents, do not resuscitate status, patient unwilling to consider revascularization, technically not feasible to perform revascularization, or comorbidities likely to markedly increase procedural risk substantially) unless specifically noted.

Definitions

A complete set of definitions of terms used throughout the clinical scenarios is listed in Appendix A. These definitions were provided to and discussed with the technical panel prior to the rating of indications.

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Maximal Anti-Ischemic Medical Therapy

As previously stated, the indications assume that patients are receiving risk factor modification according to guideline-based recommendations. For the purposes of the clinical scenarios presented, **maximal antianginal medical therapy is defined as the use of at least 2 classes of therapies to reduce anginal symptoms**.

Stress Testing and Risk of Findings on Noninvasive Testing

Stress testing is commonly used for both diagnosis and risk stratification of patients with coronary artery disease. Using criteria defined for traditional exercise stress tests (14):

Low-risk stress test findings: associated with a cardiac mortality of less than 1% per year

Intermediate-risk stress test findings: associated with a 1% to 3% per year cardiac mortality

High-risk stress test findings: associated with a greater than 3% per year cardiac mortality

Examples of findings from noninvasive studies and their associated level of risk for cardiac mortality are presented in Table A2 (13). As noted in the footnote to this table, for certain low-risk findings, there may be additional findings that alter the assessment of risk, but these relationships have not been well studied. Implicit in these risk definitions is a measure of the amount of myocardium at risk, or ischemic myocardium. For the purpose of the indications for coronary revascularization, stress test findings are presented by these risk criteria. For patients without stress test findings, please refer to the note below on invasive methods of determining hemodynamic significance. Assume that when prior testing (including an imaging procedure) is referenced in an indication, the testing was performed correctly and with sufficient quality so as to produce a meaningful and accurate result within the limits of the test performance.

For the purposes of the clinical scenarios in this document, patients with both typical and atypical angina are classified by the feature of the CCS grading system presented below. Patients with noncardiac chest pain should be considered to be asymptomatic.

Grading of Angina Pectoris by the Canadian Cardiovascular Society Classification System (15)

Class I: Ordinary physical activity does not cause angina, such as walking, climbing stairs. Angina occurs with strenuous, rapid, or prolonged exertion at work or recreation.

Class II: Slight limitation of ordinary activity. Angina occurs on walking more than 2 blocks on the level and climbing more than 1 flight of ordinary stairs at a normal pace and in normal condition.

Class III: Marked limitations of ordinary physical activity. Angina occurs on walking 1 or 2 blocks on the level and climbing 1 flight of stairs in normal conditions and at a normal pace.

Class IV: Inability to carry on any physical activity without discomfort—anginal symptoms may be present at rest.

High-Risk Features for Short-Term Risk of Death or Nonfatal MI for UA/NSTEMI (16)

At least 1 of the following:

- History—accelerating tempo of ischemic symptoms in preceding 48 hours
- Character of pain—prolonged ongoing (greater than 20 minutes) rest pain
- Clinical findings
  - Pulmonary edema, most likely due to ischemia
  - New or worsening mitral regurgitation murmur
  - S_3 or new/worsening rales
  - Hypotension, bradycardia, tachycardia
  - Age greater than 75 years
- Electrocardiogram
  - Angina at rest with transient ST-segment changes greater than 0.5 mm
  - Bundle-branch block, new or presumed new
  - Sustained ventricular tachycardia
- Cardiac marker
  - Elevated cardiac TnT, TnI, or CK-MB (e.g., TnT or TnI greater than 0.1 ng per mL)

TIMI Risk Score—for Patients With Suspected ACS (17)

Variables (1 point each)

- Age ≥65 years
- ≥3 risk factors (hypertension, diabetes mellitus, family history, lipids, smoking)
- Known CAD (stenosis ≥50%)
- Aspirin use in past 7 days
- Severe angina (≥2 episodes within 24 hours)
- ST-segment deviation ≥0.5 mm
- Elevated cardiac markers

Risk of death or ischemic event through 14 days

- Low: 0–2 (<8.3% event rate)
- Intermediate: 3–4 (<19.3% event rate)
- High: 5–7 (41% event rate)

Abbreviations

CABG = coronary artery bypass grafting
CAD = coronary artery disease
CCS = Canadian Cardiovascular Society
CTO = chronic total occlusion
FFR = fractional flow reserve
HF = heart failure

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Table A. Focused Update: New or Revised Indications

	Indication	Appropriate Use Score (1–9)	
	Patients With Acute Coronary Syndromes		
9.	• UA/NSTEMI and low-risk features (e.g., TIMI score ≤2) for short-term risk of death or nonfatal MI • Revascularization of the presumed culprit artery	U (6)	
10.	• UA/NSTEMI and intermediate-risk features (e.g., TIMI score 3–4) for short-term risk of death or nonfatal MI • Revascularization of the presumed culprit artery	A (8)	
	Patients Without Prior Bypass Surgery Asymptomatic		
20.	• One- or 2-vessel CAD without involvement of proximal LAD • No noninvasive testing performed	I (3)	
	Method of Revascularization: Multivessel CAD, CCS Angina Greater Than or Equal to Class III, and/or Evidence of Intermediate- to High-Risk Findings on Noninvasive Testing		
		PCI	CABG
62.	• Two-vessel CAD with proximal LAD stenosis	A (7)	A (8)
63.	• Three-vessel CAD with low CAD burden (i.e., 3 focal stenoses, low SYNTAX score)	A (7)	A (9)
64.	• Three-vessel CAD with intermediate to high CAD burden (i.e., multiple diffuse lesions, presence of CTO, or high SYNTAX score)	U (4)	A (9)
65.	• Isolated left main stenosis	U (6)	A (9)
66.	• Left main stenosis and additional CAD with low CAD burden (i.e., 1- to 2-vessel additional involvement, low SYNTAX score)	U (5)	A (9)
67.	• Left main stenosis and additional CAD with intermediate to high CAD burden (i.e., 3-vessel involvement, presence of CTO, or high SYNTAX score)	I (3)	A (9)

A = appropriate; CAD = coronary artery disease; CCS = Canadian Cardiovascular Society; CTO = chronic total occlusion; I = inappropriate; LAD = left anterior descending coronary artery; MI = myocardial infarction; SYNTAX = Synergy Between PCI With TAXUS and Cardiac Surgery; TIMI = Thrombolysis In Myocardial Infarction; U = uncertain; UA/NSTEMI = unstable angina/non–ST-segment elevation myocardial infarction.

IVUS = intravascular ultrasound
LAD = left anterior descending artery
LIMA = left internal mammary artery
LV = left ventricular
LVEF = left ventricular ejection fraction
MI = myocardial infarction
PCI = percutaneous coronary intervention
STEMI = ST-segment elevation myocardial infarction
TIMI = Thrombolysis In Myocardial Infarction
UA/NSTEMI = unstable angina/non–ST-segment elevation myocardial infarction

Results of Updated Ratings

The writing group evaluated the previous 180 clinical scenarios and identified those where reevaluation, expansion, or consolidation was felt necessary (Table A). Nine of the 15 updated indications met the definition of agreement as described above. There were no ratings where the technical panel held such opposing viewpoints that the technical panel's votes were determined to be in "disagreement" as defined by the strict RAND definitions and described previously in the Methods section.

As the majority of the original clinical scenarios and ratings were not rerated in this update, Table A represents the focused update indications. In addition, the entire list of 171 clinical scenarios and their appropriateness scores are shown below in Tables 1, 2, 3, and 4. Figures 1, 2, 3, 4, and 5 demonstrate gradients in appropriate use rating by increasingly severe symptom status and ischemic risk, and by the method of revascularization. These are also presented in a format similar to the original document. In addition to the changes reflected in Table A, the fractional flow reserve (FFR) cut point was updated from 0.75 to 0.80 in indication 22 to reflect new literature since the publication of the original document and to maintain consistency with guidelines (18).

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Coronary Revascularization Appropriate Use Criteria (by Indication)

Table 1. Patients With Acute Coronary Syndromes

	Indication	Appropriate Use Score (1–9)
1.	• STEMI • Less than or equal to 12 hours from onset of symptoms • Revascularization of the culprit artery	A (9)
2.	• STEMI • Onset of symptoms within the prior 12 to 24 hours • Severe HF, persistent ischemic symptoms, or hemodynamic or electrical instability present	A (9)
3.	• STEMI • Greater than 12 hours from symptom onset • Asymptomatic; no hemodynamic instability and no electrical instability	I (3)
4.	• STEMI with presumed successful treatment with fibrinolysis • Evidence of HF, recurrent ischemia, or unstable ventricular arrhythmias present • One-vessel CAD presumed to be the culprit artery	A (9)
5.	• STEMI with presumed successful treatment with fibrinolysis • Asymptomatic; no HF or no recurrent ischemic symptoms, or no unstable ventricular arrhythmias • Normal LVEF • One-vessel CAD presumed to be the culprit artery	U (5)
6.	• STEMI with presumed successful treatment with fibrinolysis • Asymptomatic; no HF, no recurrent ischemic symptoms, or no unstable ventricular arrhythmias at time of presentation • Depressed LVEF • Three-vessel CAD • Elective/semielective revascularization	A (8)
7.	• STEMI with successful treatment of the culprit artery by primary PCI or fibrinolysis • Asymptomatic; no HF, no evidence of recurrent or provokable ischemia, or no unstable ventricular arrhythmias during index hospitalization • Normal LVEF • Revascularization of a non-infarct-related artery during index hospitalization	I (2)
8.	• STEMI or NSTEMI and successful PCI of culprit artery during index hospitalization • Symptoms of recurrent myocardial ischemia and/or high-risk findings on noninvasive stress testing performed after index hospitalization • Revascularization of ≥1 additional coronary arteries	A (8)
9.	• UA/NSTEMI and low-risk features (e.g., TIMI score ≤2) for short-term risk of death or nonfatal MI • Revascularization of the presumed culprit artery	U (6)
10.	• UA/NSTEMI and intermediate-risk features (e.g., TIMI score 3–4) for short-term risk of death or nonfatal MI • Revascularization of the presumed culprit artery	A (8)
11.	• UA/NSTEMI and high-risk features for short-term risk of death or nonfatal MI • Revascularization of the presumed culprit artery	A (9)
12.	• UA/NSTEMI and high-risk features for short-term risk of death or nonfatal MI • Revascularization of multiple coronary arteries when the culprit artery cannot clearly be determined	A (9)
13.	• Patients with acute myocardial infarction (STEMI or NSTEMI) • Evidence of cardiogenic shock • Revascularization of ≥1 coronary arteries	A (8)

New and updated indications are shaded blue.

A = appropriate; CAD = coronary artery disease; HF = heart failure; I = inappropriate; LVEF = left ventricular ejection fraction; MI = myocardial infarction; NSTEMI = non–ST-segment elevation myocardial infarction; PCI = percutaneous coronary intervention; STEMI =ST-segment elevation myocardial infarction; TIMI = Thrombolysis In Myocardial Infarction; U = uncertain; UA = unstable angina.

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Table 2. Patients Without Prior Bypass Surgery

Indication		Appropriate Use Score (1–9)		
	CCS Angina Class	Asymptomatic	I or II	III or IV
14.	• One- or 2-vessel CAD without involvement of proximal LAD • Low-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	I (1)	I (2)	U (5)
15.	• One- or 2-vessel CAD without involvement of proximal LAD • Low-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	I (2)	U (5)	A (7)
16.	• One- or 2-vessel CAD without involvement of proximal LAD • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	I (3)	U (5)	U (6)
17.	• One- or 2-vessel CAD without involvement of proximal LAD • Intermediate-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (4)	A (7)	A (8)
18.	• One- or 2-vessel CAD without involvement of proximal LAD • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (6)	A (7)	A (8)
19.	• One- or 2-vessel CAD without involvement of proximal LAD • High-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	A (7)	A (8)	A (9)
20.	• One- or 2-vessel CAD without involvement of proximal LAD • No noninvasive testing performed	I (3)	U (5)	A (7)
21.	• One- or 2-vessel CAD with borderline stenosis “50% to 60%” • No noninvasive testing performed • No further invasive evaluation performed (i.e., FFR, IVUS)	Not rated	I (2)	I (3)
22.	• One- or 2-vessel CAD with borderline stenosis “50% to 60%” • No noninvasive testing performed or equivocal test results present • FFR less than or equal to 0.80* and/or IVUS with significant reduction in cross-sectional area	I (3)	U (6)	A (7)
23.	• One- or 2-vessel CAD with borderline stenosis “50% to 60%” • No noninvasive testing performed or equivocal test results present • FFR or IVUS findings do not meet criteria for significant stenosis	I (1)	I (2)	I (2)
24.	• Chronic total occlusion of 1 major epicardial coronary artery, without other coronary stenoses • Low-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	I (1)	I (2)	I (3)
25.	• Chronic total occlusion of 1 major epicardial coronary artery, without other coronary stenoses • Low-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	I (1)	U (4)	U (6)
26.	• Chronic total occlusion of 1 major epicardial coronary artery, without other coronary stenoses • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	I (3)	U (4)	U (6)
27.	• Chronic total occlusion of 1 major epicardial coronary artery, without other coronary stenoses • Intermediate-risk criteria on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (4)	U (5)	A (7)
28.	• Chronic total occlusion of 1 major epicardial coronary artery, without other coronary stenoses • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (4)	U (5)	A (7)
29.	• Chronic total occlusion of 1 major epicardial coronary artery, without other coronary stenoses • High-risk criteria on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (5)	A (7)	A (8)
30.	• One-vessel CAD involving the proximal LAD • Low-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (4)	U (5)	A (7)

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Table 2. Continued

Indication		Appropriate Use Score (1–9)		
	CCS Angina Class	Asymptomatic	I or II	III or IV
31.	• One-vessel CAD involving the proximal LAD • Low-risk findings on noninvasive testing • Receiving maximal anti-ischemic medical therapy	U (4)	A (7)	A (8)
32.	• One-vessel CAD involving the proximal LAD • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (4)	U (6)	A (7)
33.	• One-vessel CAD involving the proximal LAD • Intermediate-risk findings on noninvasive testing • Receiving maximal anti-ischemic medical therapy	U (5)	A (8)	A (9)
34.	• One-vessel CAD involving the proximal LAD • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	A (7)	A (8)	A (9)
35.	• One-vessel CAD involving the proximal LAD • High-risk findings on noninvasive testing • Receiving maximal anti-ischemic medical therapy	A (7)	A (9)	A (9)
36.	• Two-vessel CAD involving the proximal LAD • Low-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (4)	U (6)	A (7)
37.	• Two-vessel CAD involving the proximal LAD • Low-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (5)	A (7)	A (8)
38.	• Two-vessel CAD involving the proximal LAD • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (5)	A (7)	A (8)
39.	• Two-vessel CAD involving the proximal LAD • Intermediate-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (6)	A (7)	A (9)
40.	• Two-vessel CAD involving the proximal LAD • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	A (7)	A (8)	A (9)
41.	• Two-vessel CAD involving the proximal LAD • High-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	A (8)	A (9)	A (9)
42.	• Three-vessel CAD (no left main) • Low-risk findings on noninvasive testing including normal LV systolic function • Receiving no or minimal anti-ischemic medical therapy	U (5)	U (6)	A (7)
43.	• Three-vessel CAD (no left main) • Low-risk findings on noninvasive testing including normal LV systolic function • Receiving a course of maximal anti-ischemic medical therapy	U (5)	A (7)	A (8)
44.	• Three-vessel CAD (no left main) • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	A (7)	A (7)	A (8)
45.	• Three-vessel CAD (no left main) • Intermediate-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	A (7)	A (8)	A (9)
46.	• Three-vessel CAD (no left main) • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	A (7)	A (8)	A (9)
47.	• Three-vessel CAD (no left main) • High-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	A (8)	A (9)	A (9)
48.	• Three-vessel CAD (no left main) • Abnormal LV systolic function	A (8)	A (9)	A (9)
49.	• Left main stenosis	A (9)	A (9)	A (9)

New and updated indications are shaded blue. *FFR cut point updated from 0.75 to 0.80 to reflect new literature since publication of the original document and to maintain consistency with guidelines (18).

A = appropriate; CAD = coronary artery disease; CCS = Canadian Cardiovascular Society; I = inappropriate; LAD = left anterior descending coronary artery; LV = left ventricular; LVEF = left ventricular ejection fraction; U = uncertain.

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Table 3. Patients With Prior Bypass Surgery (Without Acute Coronary Syndrome)

Indication		Appropriate Use Score (1–9)		
	CCS Angina Class	Asymptomatic	I or II	III or IV
50.	• One or more stenoses in saphenous vein graft(s) • Low-risk findings on noninvasive testing including normal LV systolic function • Receiving no or minimal anti-ischemic medical therapy	I (3)	U (4)	U (6)
51.	• One or more stenoses in saphenous vein graft(s) • Low-risk findings on noninvasive testing including normal LV systolic function • Receiving a course of maximal anti-ischemic medical therapy	U (4)	U (6)	A (7)
52.	• One or more stenoses in saphenous vein graft(s) • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (4)	U (6)	A (7)
53.	• One or more stenoses in saphenous vein graft(s) • Intermediate-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (4)	A (7)	A (8)
54.	• One or more stenoses in saphenous vein graft(s) • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (6)	A (7)	A (7)
55.	• One or more stenoses in saphenous vein graft(s) • High-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	A (7)	A (8)	A (9)
56.	• One or more lesions in native coronary arteries without bypass grafts • All bypass grafts patent and without significant disease • Low-risk findings on noninvasive testing including normal LV systolic function • Receiving no or minimal anti-ischemic medical therapy	Not rated	I (3)	U (6)
57.	• One or more lesions in native coronary arteries without bypass grafts • All bypass grafts patent and without significant disease • Low-risk findings on noninvasive testing including normal LV systolic function • Receiving a course of maximal anti-ischemic medical therapy	I (3)	U (5)	A (7)
58.	• One or more lesions in native coronary arteries without bypass grafts • All bypass grafts patent and without significant disease • Intermediate-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	I (3)	U (5)	A (7)
59.	• One or more lesions in native coronary arteries without bypass grafts • All bypass grafts patent and without significant disease • Intermediate-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (4)	U (6)	A (8)
60.	• One or more lesions in native coronary arteries without bypass grafts • All bypass grafts patent and without significant disease • High-risk findings on noninvasive testing • Receiving no or minimal anti-ischemic medical therapy	U (6)	A (7)	A (8)
61.	• One or more lesions in native coronary arteries without bypass grafts • All bypass grafts patent and without significant disease • High-risk findings on noninvasive testing • Receiving a course of maximal anti-ischemic medical therapy	U (5)	A (8)	A (9)

A = appropriate; CCS = Canadian Cardiovascular Society; I = inappropriate; LV = left ventricular; U = uncertain.

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Table 4. Method of Revascularization: Multivessel CAD, CCS Angina Greater Than or Equal to Class III, and/or Evidence of Intermediate- to High-Risk Findings on Noninvasive Testing*

Indication		Appropriate Use Score (1–9)	
		PCI	CABG
62.	• Two-vessel CAD with proximal LAD stenosis	A (7)	A (8)
63.	• Three-vessel CAD with low CAD burden (i.e., 3 focal stenoses, low SYNTAX score)	A (7)	A (9)
64.	• Three-vessel CAD with intermediate to high CAD burden (i.e., multiple diffuse lesions, presence of CTO, or high SYNTAX score)	U (4)	A (9)
65.	• Isolated left main stenosis	U (6)	A (9)
66.	• Left main stenosis and additional CAD with low CAD burden (i.e., 1- to 2-vessel additional involvement, low SYNTAX score)	U (5)	A (9)
67.	• Left main stenosis and additional CAD with intermediate to high CAD burden (i.e., 3-vessel involvement, presence of CTO, or high SYNTAX score)	I (3)	A (9)
68.	• Prior bypass surgery with native 3-vessel disease and failure of multiple bypass grafts • LIMA remains patent to a native coronary artery • Depressed LVEF	U (6)	A (7)
69.	• Prior bypass surgery with native 3-vessel disease and failure of multiple bypass grafts • LIMA was used as a graft but is no longer functional • Depressed LVEF	A (8)	U (6)

New and updated indications are shaded blue. *The 2009 appropriate use criteria (1) separated out diabetes and normal or depressed LVEF for the indications in this table, but they were combined for the focused update because these clinical variables did not affect the ratings.

A = appropriate; CABG = coronary artery bypass graft; CAD = coronary artery disease; CCS = Canadian Cardiovascular Society; CTO = chronic total occlusion; I = inappropriate; LAD = left anterior descending coronary artery; LIMA = left internal mammary artery; LVEF = left ventricular ejection fraction; PCI = percutaneous coronary intervention; SYNTAX = Synergy Between PCI With TAXUS and Cardiac Surgery; U = uncertain.

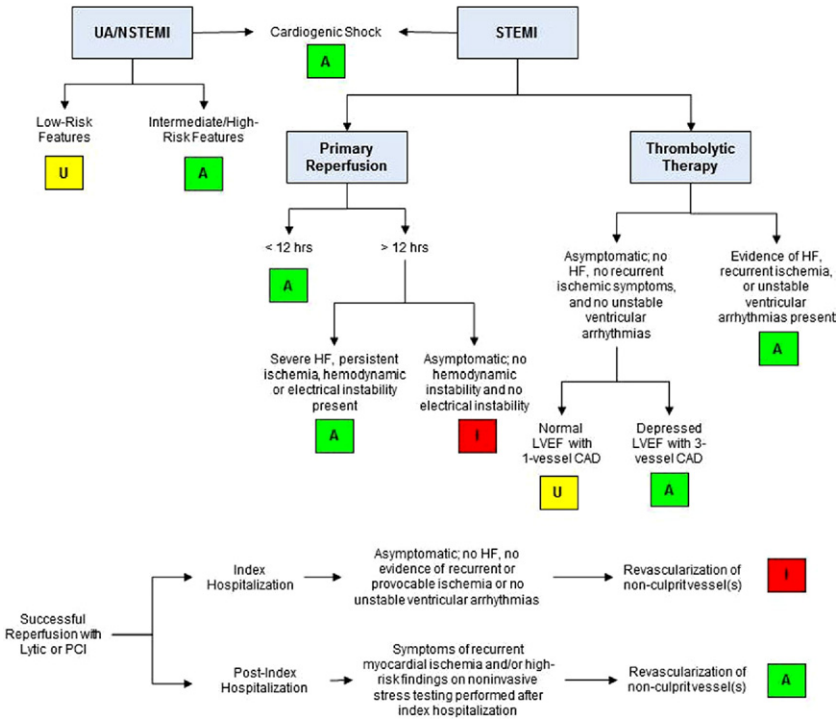

Figure 1. Appropriate Use Ratings for Revascularization in Acute Coronary Syndromes*

*The fact that the use of coronary revascularization for a particular condition is listed in this figure (appropriate, uncertain, inappropriate) does not preclude the use of other therapeutic modalities that may be equally effective. See the most current ACCF/AHA UA/NSTEMI and STEMI guidelines (16,23). A = appropriate; CAD = coronary artery disease; HF = heart failure; I = inappropriate; LVEF = left ventricular ejection fraction; PCI = percutaneous coronary intervention; STEMI = ST-elevation myocardial infarction; U = uncertain; UA/NSTEMI = unstable angina/non–ST-elevation myocardial infarction.

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Low-Risk Findings on Noninvasive Study						Asymptomatic					
Symptoms Med. Rx						**Stress Test Med. Rx**					
Class III or IV Max Rx	U	A	A	A	A	High Risk Max Rx	U	A	A	A	A
Class I or II Max Rx	U	U	A	A	A	High Risk No/min Rx	U	U	A	A	A
Asymptomatic Max Rx	I	I	U	U	U	Int. Risk Max Rx	U	U	U	U	A
Class III or IV No/min Rx	I	U	A	A	A	Int. Risk No/min Rx	I	I	U	U	A
Class I or II No/min Rx	I	I	U	U	U	Low Risk Max Rx	I	I	U	U	U
Asymptomatic No/min Rx	I	I	U	U	U	Low Risk No/min Rx	I	I	U	U	U
Coronary Anatomy	CTO of 1-vz.; no other disease	1-2-vz. disease; no prox. LAD	1-vz. disease of prox. LAD	2-vz. disease with prox. LAD	3-vz. disease; no left main	Coronary Anatomy	CTO of 1-vz.; no other disease	1-2-vz. disease; no prox. LAD	1-vz. disease of prox. LAD	2-vz. disease with prox. LAD	3-vz. disease; no left main

Figure 2. Appropriate Use Ratings by Low-Risk Findings on Noninvasive Imaging Study and Asymptomatic (Patients Without Prior Bypass Surgery)

A = appropriate; CTO = chronic total occlusion; I = inappropriate; Int. = intermediate; Max = maximum; min = minimal; Med. = medical; prox. LAD = proximal left anterior descending artery; Rx = treatment; U = uncertain; vz. = vessel.

Intermediate Risk Findings on Noninvasive Study						CCS Class I or II Angina					
Symptoms Med. Rx						**Stress Test Med. Rx**					
Class III or IV Max Rx	A	A	A	A	A	High Risk Max Rx	A	A	A	A	A
Class I or II Max Rx	U	A	A	A	A	High Risk No/min Rx	U	A	A	A	A
Asymptomatic Max Rx	U	U	U	U	A	Int. Risk Max Rx	U	A	A	A	A
Class III or IV No/min Rx	U	U	A	A	A	Int. Risk No/min Rx	U	U	U	A	A
Class I or II No/min Rx	U	U	U	A	A	Low Risk Max Rx	U	U	A	A	A
Asymptomatic No/min Rx	I	I	U	U	A	Low Risk No/min Rx	I	I	U	U	U
Coronary Anatomy	CTO of 1 vz.; no other disease	1-2 vz. disease; no Prox. LAD	1 vz. disease of Prox. LAD	2 vz. disease with Prox. LAD	3 vz. disease; no Left Main	**Coronary Anatomy**	CTO of 1 vz.; no other disease	1-2 vz. disease; no Prox. LAD	1 vz. disease of Prox. LAD	2 vz. disease with Prox. LAD	3 vz. disease; no Left Main

Figure 3. Appropriate Use Ratings by Intermediate-Risk Findings on Noninvasive Imaging Study and CCS Class I or II Angina (Patients Without Prior Bypass Surgery)

A = appropriate; CCS = Canadian Cardiovascular Society; CTO = chronic total occlusion; I = inappropriate; Int. = intermediate; Max = maximum; min = minimal; Med. = medical; prox. LAD = proximal left anterior descending artery; Rx = treatment; U = uncertain; vz. = vessel.

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High-Risk Findings on Noninvasive Study						CCS Class III or IV Angina					
Symptoms Med. Rx						Stress Test Med. Rx					
Class III or IV Max Rx	A	A	A	A	A	High Risk Max Rx	A	A	A	A	A
Class I or II Max Rx	A	A	A	A	A	High Risk No/min Rx	A	A	A	A	A
Asymptomatic Max Rx	U	A	A	A	A	Int. Risk Max Rx	A	A	A	A	A
Class III or IV No/min Rx	A	A	A	A	A	Int. Risk No/min Rx	U	U	A	A	A
Class I or II No/min Rx	U	A	A	A	A	Low Risk Max Rx	U	A	A	A	A
Asymptomatic No/min Rx	U	U	A	A	A	Low Risk No/min Rx	I	U	A	A	A
Coronary Anatomy	CTO of 1-vz.; no other disease	1-2-vz. disease; no prox. LAD	1-vz. disease of prox. LAD	2-vz. disease with prox. LAD	3-vz. disease; no left main	Coronary Anatomy	CTO of 1-vz.; no other disease	1-2-vz. disease; no prox. LAD	1-vz. disease of prox. LAD	2-vz. disease with prox. LAD	3-vz. disease; no left main

Figure 4. Appropriate Use Ratings by High-Risk Findings on Noninvasive Imaging Study and CCS Class III or IV Angina (Patients Without Prior Bypass Surgery)

A = appropriate; CCS = Canadian Cardiovascular Society; CTO = chronic total occlusion; I = inappropriate; Int. = intermediate; Max = maximum; min = minimal; Med. = medical; prox. LAD = proximal left anterior descending artery; Rx = treatment; U = uncertain; vz. = vessel.

	CABG	PCI
Two-vessel CAD with proximal LAD stenosis	A	A
Three-vessel CAD with low CAD burden (i.e., three focal stenosis, low SYNTAX score)	A	A
Three-vessel CAD with intermediate to high CAD burden (i.e., multiple diffuse lesions, presence of CTO, or high SYNTAX score)	A	U
Isolated left main stenosis	A	U
Left main stenosis and additional CAD with low CAD burden (i.e., one to two vessel additional involvement, low SYNTAX score)	A	U
Left main stenosis and additional CAD with intermediate to high CAD burden (i.e., three vessel involvement, presence of CTO, or high SYNTAX score)	A	I

Figure 5. Method of Revascularization of Multivessel Coronary Artery Disease

A = appropriate; CABG = coronary artery bypass grafting; CAD = coronary artery disease; CTO = chronic total occlusion; I = inappropriate; LAD = left anterior descending artery; PCI = percutaneous coronary intervention; SYNTAX = Synergy Between PCI With TAXUS and Cardiac Surgery; U = uncertain.

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Rating Revascularization Methods

Mode of Revascularization (Indications 62 to 69)

Recognizing that variability in revascularization methods is often based upon patient factors and local practice patterns, the majority of indications are not intended to distinguish between the specific modes of revascularization (i.e., PCI vs. CABG). However, the writing group recognized that among patients with extensive or complex atherosclerosis, the mode of revascularization is also of interest when revascularization is deemed appropriate. Therefore, Table 4 presents clinical scenarios where the technical panelists were asked to consider the appropriate use of PCI and CABG as the revascularization method independently of each other (such that each modality would receive separate scores based on each specific clinical indication). These ratings are not intended to be a competitive ranking of PCI versus CABG, or to prioritize a specific approach when both are rated to have the same level of appropriateness.

Many of the known clinical factors that increase the risk of revascularization are shared between CABG and percutaneous methods. In the original AUC for revascularization, clinical scenarios were developed that included diabetes and LV function to stratify patients, but when rated, these features did not result in different ratings and thus were not used in this focused update. However, in an attempt to further stratify patients, the SYNTAX score is used in some of the new clinical scenarios.

The clinical scenarios below specifically apply to patients with multivessel CAD. It is assumed for these clinical scenarios that all patients have unacceptable levels of symptoms despite appropriate medical therapy and evidence of intermediate- to high-risk findings on noninvasive testing. In other words, the technical panel assumed that revascularization is appropriate and focused on rating the merit of the different modes with the intent of complete coronary revascularization for each indication.

In addition, it is assumed that no unusual extenuating circumstances exist (inability to comply with antiplatelet agents, patient is do not resuscitate status, patient preference strongly favoring 1 therapy or comorbidities likely to markedly increase procedural risk substantially). As such, the technical panel rated the appropriateness of PCI and CABG based on the information in the indication alone, assuming other variables are not present that would impact the decision.

Discussion

The ultimate objective of AUC is to improve patient care and health outcomes. The ACCF and its collaborators believe that careful blending of a broad range of clinical experiences and available evidence-based information will help guide a more efficient and equitable allocation of healthcare resources in cardiovascular revascularization. This approach is not intended to diminish the acknowledged difficulty or uncertainty of clinical decision making. Appropriate use criteria are not substitutes for sound clinical judgment and practice experience. It is acknowledged that some patients seen in clinical practice may not be represented in the AUC or have extenuating features when compared with the clinical scenarios presented.

Since the publication of the original coronary revascularization AUC, there has been substantial national focus on the variability and appropriateness of coronary revascularization. The 2009 AUC specifically for coronary revascularization by PCI has been mapped to the National Cardiovascular Data, Registry (NCDR) CathPCI registry data, and each institution's benchmarked results are now provided to member facilities in quarterly reports as a test quality metric. This initial assessment of PCI appropriateness within the NCDR data was also published by Chan and colleagues (19). Hospitals and operators are encouraged to review their specific reports as part of a quality improvement program to ensure data accuracy and increase the use of appropriate revascularization. Additionally, the SYNTAX trial, which was not formally published until 2009, was anticipated to possibly have an impact on the AUC. Despite calls for earlier updates of specific clinical scenarios, such as the isolated left main coronary artery revascularization, the writing group awaited the peer-reviewed publication of both the original trial data and the intermediate-term follow-up.

This focused update highlights 2 specific areas that were felt to require reconsideration: 1) specific indications that represent gaps identified when mapping the 2009 AUC to the CathPCI registry; and 2) re-evaluation of the indications for the treatment of multivessel CAD with symptoms by method (PCI and CABG) of revascularization as a result of data from the SYNTAX trial.

New Clinical Scenarios to Address Gaps

The 2009 AUC document only had 1 clinical scenario for UA/NSTEMI and high-risk features, which was graded as appropriate. The ratings for these new clinical scenarios (Indications 9 and 10) focus on patients with UA/NSTEMI and low- or intermediate-risk features as determined by the TIMI score. Revascularization in such patients with a low-risk score was graded as uncertain, meaning that revascularization may be reasonable, with the caveat that there is limited data on clinical benefit. For patients with an intermediate-risk score, revascularization was rated appropriate as it was for patients at high risk (Fig. 1).

In the 2009 AUC document, the clinical scenario of an asymptomatic patient without prior bypass surgery and with 1- or 2-vessel disease not involving the proximal LAD in whom no noninvasive testing had been performed was not evaluated because this clinical scenario was felt to be uncommon. However, for future mapping of the AUC to the CathPCI registry, the appropriateness of this clinical scenario was graded

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in this focused update and determined to be inappropriate. This did not affect the appearance of Figures 2, 3, and 4 below because they include indications that were not updated.

PCI and CABG in Patients With Multivessel CAD

In this group of ratings, it is assumed that revascularization is appropriate, and the technical panel rated the appropriateness of the mode of revascularization independently for CABG and PCI (Fig. 5). The writing group and technical panel felt some quantification of CAD burden, either by description or SYNTAX score, could be helpful to clinicians. CABG was rated as appropriate in all of the new clinical scenarios developed, whereas PCI was rated as appropriate only in patients with 2-vessel CAD with involvement of the proximal LAD and in patients with 3-vessel disease with a low CAD burden. PCI for 3-vessel disease with a high CAD burden, however, was rated as uncertain. PCI for isolated left main stenosis is now graded as uncertain, as are scenarios with 3-vessel CAD with intermediate to high CAD burden and left main stenosis and additional CAD with low CAD burden. PCI is considered inappropriate for left main stenosis and additional CAD with intermediate to high CAD burden.

Clinical Judgment and Understanding the AUC Ratings

Although the appropriate use ratings reflect a general assessment of when revascularization may or may not be useful for specific patient populations, physicians and other stakeholders should continue to acknowledge the pivotal role of clinical judgment in determining whether revascularization is indicated for an individual patient. For example, the rating of a revascularization indication as inappropriate or uncertain should not preclude a provider from performing revascularization procedures when there are patient- and condition-specific data to support that decision. Indeed, this may reflect optimal clinical care, if supported by mitigating patient characteristics. Likewise, uncertain indications require individual physician judgment and understanding of the patient to better determine the usefulness of revascularization for a particular clinical scenario. The ranking of uncertain (4 to 6) **should not be viewed as excluding the use of revascularization for such patients**. Finally, there may be clinical scenarios in which the use of coronary revascularization for an indication considered to be appropriate does not always represent reasonable practice, such that the benefit of the procedure does not outweigh the risks. Accordingly, the AUC are intended to evaluate overall patterns of care regarding revascularization rather than adjudicating specific cases. In situations where there is substantial variation between the appropriate use rating and what the clinician believes is the best recommendation for the patient, further considerations or actions such as a second opinion may be appropriate. It is not anticipated that all physicians or facilities will have 100% of their revascularization procedures deemed appropriate. However, related to the overall patterns of care, if the national average of appropriate procedure ratings is 80%, e.g., and a physician or facility has only a 40% rate of appropriate procedures, further examination of the patterns of care may be warranted and helpful.

Stable Ischemic Heart Disease *With* Prior CABG

The writing group did not feel the focused update needed to address any clinical scenarios in patients with stable ischemic heart disease and prior CABG. These indications from the prior document show a pattern similar to that seen in patients without prior CABG; the presence of high-risk findings on noninvasive testing, higher severity of symptoms, or an increasing burden of disease in either the bypass grafts or native coronaries increased the likelihood of an appropriate rating. The only inappropriate ratings in patients with prior CABG were noted in patients receiving no or minimal anti-ischemic therapy or having low-risk findings on noninvasive testing. More uncertain ratings occurred in this group of patients, reflecting their higher complexity, higher risk, and the limited availability of published evidence regarding management outcome.

Application of Criteria

There are many potential applications for the AUC. Clinicians can use the ratings for decision support or as an educational tool when considering the need for revascularization. Moreover, these criteria can be used to facilitate discussion with patients and/or referring physicians about the need for revascularization. Facilities and payers may choose to use these criteria either prospectively in the design of protocols or pre-authorization procedures, or retrospectively for quality reports. It is hoped that payers would use these criteria to ensure that their members receive necessary, beneficial, and cost-effective cardiovascular care, rather than for other purposes.

It is expected that services performed for appropriate indications will receive reimbursement. In contrast, services performed for inappropriate indications may require additional documentation to justify payment because of the unique circumstances or the clinical profile that may exist in such a patient. This additional documentation should not be required for uncertain indications. It is critical to emphasize that the writing group, technical panel, AUC Task Force, and clinical community do not believe an uncertain rating justifies denial of reimbursement for revascularization. Rather, uncertain ratings are those in which the available data vary and many other factors exist that may affect the decision to perform or not perform revascularization. The opinions of the technical panel often varied for these indications, reflecting that additional research is needed. Indications with high clinical volume that are rated as uncertain identify important areas for further research. The AUC writing group and technical panel favor the collaborative interaction of cardiac surgeons and interventional cardiologists Heart Team approach regarding revascularization decisions in complex patients or coronary anatomy.

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When evaluating physician or facility performance, AUC should be used in conjunction with efforts that lead to quality improvement. Prospective pre-authorization procedures, if put in place, are most effective once a retrospective review has identified a pattern of potential inappropriate use. Because these criteria are based on current scientific evidence and the deliberations of the technical panel, they should be used prospectively to generate future discussions about reimbursement, but should not be applied retrospectively to cases completed before issuance of this report or documentation of centers/providers performing an unexpectedly high proportion of inappropriate cases as compared with their peers.

The writing group recognizes that these criteria will be evaluated during routine clinical care. To that end, specific data fields such as symptom status, presence or absence of acute coronary syndrome, history of bypass surgery, extent of ischemia on noninvasive imaging, CAD burden, and degree of antianginal therapy are anticipated to provide sufficient detail to determine individual appropriate use ratings. Because a reasonable and tolerated dose of antianginal therapy may vary significantly among different patients, the writing group continues to recommend the use of 2 classes of antianginal therapies as a minimum standard for medical therapy. The writing group also recognizes all data (e.g., visual assessment of stenosis severity, interpretation of noninvasive imaging, symptom severity) collected to assess appropriate use relies on its content accurately reflecting actual patient characteristics. Any current variability in these data points need to be addressed before accurate determination of appropriate use can be provided.

The primary objective of this report is to provide guidance regarding the suitability of coronary revascularization for diverse clinical scenarios. As with previous AUC documents, consensus among the technical panel members was desirable, but an attempt to achieve complete agreement within this diverse panel would have been artificial and was not the goal of the process. Two rounds of ratings with substantial discussion among the technical panel members between the ratings did lead to some consensus among panelists. However, further attempts to drive consensus would have diluted true differences in opinion among panelists and, therefore, was not undertaken. Moreover, remarkable concordance between the appropriateness ratings from the original criteria and 85 cardiologists not participating in the process, and blinded to the initial results, has been documented (20).

Future research analyzing patient outcomes for indications rated as appropriate will help ensure the equitable and efficient allocation of resources for coronary revascularization. Review of appropriateness patterns may also improve understanding of regional variations in the use of revascularization as highlighted in the Dartmouth Atlas Project (21). Further exploration of the indications rated as uncertain will help generate the information required to further define the appropriate use of coronary revascularization. Additionally, the criteria will need to be updated with the publication of ongoing trials in coronary revascularization and new clinical practice guidelines. For additional information and discussion of the literature, please see the ACCF/AHA PCI and CABG guidelines (12,13).

In conclusion, this document represents the current understanding of the clinical benefit of coronary revascularization with respect to health outcomes and survival. It is intended to provide a practical guide to clinicians and patients when considering revascularization. As with other AUC, the results of some of these ratings will require research and further evaluation to provide the greatest information and benefit to clinical decision making.

Appendix A: Additional Coronary Revascularization Definitions

Angina/Chest Pain Classification

Angina is a syndrome typically noted to include discomfort in the chest, jaw, shoulder, back, or arm that is aggravated by exertion or emotional stress and relieved by nitroglycerin. The quality of the discomfort, provoking factors, and relieving factors are used to define typical, atypical, and noncardiac chest pain. Atypical angina is generally defined by 2 of the above 3 characteristics, and noncardiac chest pain is generally defined as chest pain that meets 1 or none of the above criteria. These definitions are presented below.

Clinical Classification of Chest Pain (22):

- ***Typical* Angina (Definite):** Defined as 1) substernal chest pain or discomfort that is 2) provoked by exertion or emotional stress and 3) relieved by rest and/or nitroglycerin.
- ***Atypical* Angina (Probable):** Chest pain or discomfort that **lacks 1** of the characteristics of definite or typical angina.
- ***Nonanginal* Chest Pain:** Chest pain or discomfort that **meets 1 or none** of the typical angina characteristics.

The writing group assumes that noninvasive assessments of coronary anatomy (i.e., cardiac computed tomography, cardiac magnetic resonance angiography) provide anatomic information that is potentially similar to x-ray angiography. However, these modalities do not currently provide information on ischemic burden and are not assumed to be present in the clinical scenarios.

Invasive Methods of Determining Hemodynamic Significance

The writing group recognizes that not all patients referred for revascularization will have previous noninvasive testing. In fact, there are several situations in which patients may be appropriately referred for coronary angiography based on symptom presentation and a high pretest probability of coronary artery disease. In these settings, there may be

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Table A2. Noninvasive Risk Stratification

High-risk (>3% annual mortality rate)
1. Severe resting left ventricular dysfunction (LVEF <35%)
2. High-risk treadmill score (score ≤−11)
3. Severe exercise left ventricular dysfunction (exercise LVEF <35%)
4. Stress-induced large perfusion defect (particularly if anterior)
5. Stress-induced multiple perfusion defects of moderate size
6. Large, fixed perfusion defect with LV dilation or increased lung uptake (thallium-201)
7. Stress-induced moderate perfusion defect with LV dilation or increased lung uptake (thallium-201)
8. Echocardiographic wall motion abnormality (involving >2 segments) developing at low dose of dobutamine (≤10 mg/kg/min) or at a low heart rate (<120 beats/min)
9. Stress echocardiographic evidence of extensive ischemia
Intermediate-risk (1% to 3% annual mortality rate)
1. Mild/moderate resting left ventricular dysfunction (LVEF 35% to 49%)
2. Intermediate-risk treadmill score (score between −11 and <5)
3. Stress-induced moderate perfusion defect without LV dilation or increased lung intake (thallium-201)
4. Limited stress echocardiographic ischemia with a wall motion abnormality only at higher doses of dobutamine involving less than or equal to 2 segments
Low-risk (<1% annual mortality rate)
1. Low-risk treadmill score (score ≥5)
2. Normal or small myocardial perfusion defect at rest or with stress*
3. Normal stress echocardiographic wall motion or no change of limited resting wall motion abnormalities during stress*

*Although the published data are limited, patients with these findings will probably not be at low risk in the presence of either a high-risk treadmill score or severe resting left ventricular dysfunction (LVEF <35%). Reprinted with permission from Patel et al. (1).
LV = left ventricular; LVEF = left ventricular ejection fraction.

situations where angiography shows a coronary narrowing of questionable hemodynamic importance in a patient with symptoms that can be related to myocardial ischemia. In such patients, the use of additional invasive measurements (such as fractional flow reserve or intravascular ultrasound) at the time of diagnostic angiography may be very helpful in further defining the need for revascularization and substituted for stress test findings (Table A2).

Appendix B: Additional Methods

See the earlier Methods section of the report for a description of technical panel selection, indication development, scope of indications, and rating process.

Relationships With Industry and Other Entities

The American College of Cardiology Foundation and its partnering organizations rigorously avoid any actual, perceived, or potential conflicts of interest that might arise as a result of an outside relationship or personal interest of a member of the technical panel. Specifically, all panelists are asked to provide disclosure statements of all relationships that might be perceived as real or potential conflicts of interest. These statements were reviewed by the AUC Task Force, discussed with all members of the technical panel at the face-to-face meeting, and updated and reviewed as necessary. A table of disclosures by all participants, who are listed in Appendix C, in the Appropriate Use Criteria for Coronary Revascularization can be found in Appendix D. In addition, to ensure complete transparency, complete disclosure information—including relationships not pertinent to this document—is available online as a document supplement.

Literature Review

The technical panel members were asked to refer to the relevant guidelines for a summary of the relevant literature, guideline recommendation tables, and reference lists provided for each indication table when completing their ratings (Online Appendix).

Appendix C: ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 Appropriate Use Criteria for Coronary Revascularization Focused Update Participants

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ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 Appropriate Use Criteria for Coronary Revascularization Focused Update

American College of Cardiology Foundation Appropriate Use Criteria Task Force, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, American Association for Thoracic Surgery, American Heart Association, American Society of Nuclear Cardiology, Society of Cardiovascular Computed Tomography, American Society of Echocardiography, Heart Rhythm Society, Manesh R. Patel, Gregory J. Dehmer, John W. Hirshfeld, Peter K. Smith, and John A. Spertus

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2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery

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PRACTICE GUIDELINE

2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery

A Report of the American College of Cardiology Foundation/
American Heart Association Task Force on Practice Guidelines

Developed in Collaboration With the American Association for Thoracic Surgery, Society of Cardiovascular Anesthesiologists, and Society of Thoracic Surgeons

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Preamble

The medical profession should play a central role in evaluating the evidence related to drugs, devices, and procedures for the detection, management, and prevention of disease. When properly applied, expert analysis of available data on the benefits and risks of these therapies and procedures can improve the quality of care, optimize patient outcomes, and favorably affect costs by focusing resources on the most effective strategies. An organized and directed approach to a thorough review of evidence has resulted in the production of clinical practice guidelines that assist physicians in selecting the best management strategy for an individual patient. Moreover, clinical practice guidelines can provide a foundation for other applications, such as performance measures, appropriate use criteria, and both quality improvement and clinical decision support tools.

The American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) have jointly produced guidelines in the area of cardiovascular disease since 1980. The ACCF/AHA Task Force on Practice Guidelines (Task Force), charged with developing, updating, and revising practice guidelines for cardiovascular diseases and procedures, directs and oversees this effort. Writing committees are charged with regularly reviewing and evaluating all available evidence to develop balanced, patient-centric recommendations for clinical practice.

Experts in the subject under consideration are selected by the ACCF and AHA to examine subject-specific data and write guidelines in partnership with representatives from other medical organizations and specialty groups. Writing committees are asked to perform a formal literature review; weigh the strength of evidence for or against particular tests, treatments, or procedures; and include estimates of expected outcomes where such data exist. Patient-specific modifiers, comorbidities, and issues of patient preference that may influence the choice of tests or therapies are considered. When available, information from studies on cost is considered, but data on efficacy and outcomes constitute the primary basis for the recommendations contained herein.

In analyzing the data and developing recommendations and supporting text, the writing committee uses evidence-based methodologies developed by the Task Force (1). The Class of Recommendation (COR) is an estimate of the size of the treatment effect considering risks versus benefits in addition to evidence and/or agreement that a given treatment or procedure is or is not useful/effective or in some situations may cause harm. The Level of Evidence (LOE) is an estimate of the certainty or precision of the treatment effect. The writing committee reviews and ranks evidence supporting each recommendation with the weight of evidence ranked as LOE A, B, or C according to specific definitions that are included in Table 1. Studies are identified as observational, retrospective, prospective, or randomized where appropriate. For certain conditions for which inadequate data are available, recommendations are based on expert consensus and clinical experience and are ranked as LOE C. When recommendations at LOE C are supported by historical clinical data, appropriate references (including clinical reviews) are cited if available. For issues for which sparse data are available, a survey of current

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Table 1. Applying Classification of Recommendations and Level of Evidence

ESTIMATE OF CERTAINTY (PRECISION) OF TREATMENT EFFECT	SIZE OF TREATMENT EFFECT: CLASS I *Benefit >>> Risk* Procedure/Treatment **SHOULD** be performed/ administered	CLASS IIa *Benefit >> Risk* *Additional studies with focused objectives needed* **IT IS REASONABLE** to perform procedure/administer treatment	CLASS IIb *Benefit ≥ Risk* *Additional studies with broad objectives needed; additional registry data would be helpful* Procedure/Treatment **MAY BE CONSIDERED**	CLASS III *No Benefit* or CLASS III *Harm* Procedure/ Test / Treatment COR III: No benefit — Not Helpful / No Proven Benefit COR III: Harm — Excess Cost w/o Benefit or Harmful / Harmful to Patients
LEVEL A Multiple populations evaluated* Data derived from multiple randomized clinical trials or meta-analyses	■ Recommendation that procedure or treatment is useful/effective ■ Sufficient evidence from multiple randomized trials or meta-analyses	■ Recommendation in favor of treatment or procedure being useful/effective ■ Some conflicting evidence from multiple randomized trials or meta-analyses	■ Recommendation's usefulness/efficacy less well established ■ Greater conflicting evidence from multiple randomized trials or meta-analyses	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Sufficient evidence from multiple randomized trials or meta-analyses
LEVEL B Limited populations evaluated* Data derived from a single randomized trial or nonrandomized studies	■ Recommendation that procedure or treatment is useful/effective ■ Evidence from single randomized trial or nonrandomized studies	■ Recommendation in favor of treatment or procedure being useful/effective ■ Some conflicting evidence from single randomized trial or nonrandomized studies	■ Recommendation's usefulness/efficacy less well established ■ Greater conflicting evidence from single randomized trial or nonrandomized studies	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Evidence from single randomized trial or nonrandomized studies
LEVEL C Very limited populations evaluated* Only consensus opinion of experts, case studies, or standard of care	■ Recommendation that procedure or treatment is useful/effective ■ Only expert opinion, case studies, or standard of care	■ Recommendation in favor of treatment or procedure being useful/effective ■ Only diverging expert opinion, case studies, or standard of care	■ Recommendation's usefulness/efficacy less well established ■ Only diverging expert opinion, case studies, or standard of care	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Only expert opinion, case studies, or standard of care
Suggested phrases for writing recommendations	should is recommended is indicated is useful/effective/beneficial	is reasonable can be useful/effective/beneficial is probably recommended or indicated	may/might be considered may/might be reasonable usefulness/effectiveness is unknown/unclear/uncertain or not well established	COR III: No Benefit: is not recommended; is not indicated; should not be performed/ administered/ other; is not useful/ beneficial/ effective COR III: Harm: potentially harmful; causes harm; associated with excess morbidity/mortality; should not be performed/ administered/ other
Comparative effectiveness phrases†	treatment/strategy A is recommended/indicated in preference to treatment B treatment A should be chosen over treatment B	treatment/strategy A is probably recommended/indicated in preference to treatment B it is reasonable to choose treatment A over treatment B		

A recommendation with Level of Evidence B or C does not imply that the recommendation is weak. Many important clinical questions addressed in the guidelines do not lend themselves to clinical trials. Although randomized trials are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

*Data available from clinical trials or registries about the usefulness/efficacy in different subpopulations, such as sex, age, history of diabetes, history of prior myocardial infarction, history of heart failure, and prior aspirin use. †For comparative effectiveness recommendations (Class I and IIa; Level of Evidence A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

practice among the clinicians on the writing committee is the basis for LOE C recommendations, and no references are cited. The schema for COR and LOE is summarized in Table 1, which also provides suggested phrases for writing recommendations within each COR. A new addition to this methodology is separation of the Class III recommendations to delineate if the recommendation is determined to be of "no benefit" or is associated with "harm" to the patient. In addition, in view of the increasing number of comparative effectiveness studies, comparator verbs and suggested phrases for writing recommendations for the comparative effectiveness of one treatment or strategy versus another have been added for COR I and IIa, LOE A or B only.

In view of the advances in medical therapy across the spectrum of cardiovascular diseases, the Task Force has designated the term *guideline–directed medical therapy (GDMT)* to represent optimal medical therapy as defined by ACCF/AHA guideline–recommended therapies (primarily Class I). This new term, GDMT, will be used herein and throughout all future guidelines.

Because the ACCF/AHA practice guidelines address patient populations (and healthcare providers) residing in North America, drugs that are not currently available in North America are discussed in the text without a specific COR. For studies performed in large numbers of subjects outside North America, each writing committee reviews the

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potential influence of different practice patterns and patient populations on the treatment effect and relevance to the ACCF/AHA target population to determine whether the findings should inform a specific recommendation.

The ACCF/AHA practice guidelines are intended to assist healthcare providers in clinical decision making by describing a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines attempt to define practices that meet the needs of most patients in most circumstances. The ultimate judgment regarding the care of a particular patient must be made by the healthcare provider and patient in light of all the circumstances presented by that patient. As a result, situations may arise for which deviations from these guidelines may be appropriate. Clinical decision making should involve consideration of the quality and availability of expertise in the area where care is provided. When these guidelines are used as the basis for regulatory or payer decisions, the goal should be improvement in quality of care. The Task Force recognizes that situations arise in which additional data are needed to inform patient care more effectively; these areas will be identified within each respective guideline when appropriate.

Prescribed courses of treatment in accordance with these recommendations are effective only if followed. Because lack of patient understanding and adherence may adversely affect outcomes, physicians and other healthcare providers should make every effort to engage the patient's active participation in prescribed medical regimens and lifestyles. In addition, patients should be informed of the risks, benefits, and alternatives to a particular treatment and be involved in shared decision making whenever feasible, particularly for COR IIa and IIb, where the benefit-to-risk ratio may be lower.

The Task Force makes every effort to avoid actual, potential, or perceived conflicts of interest that may arise as a result of industry relationships or personal interests among the members of the writing committee. All writing committee members and peer reviewers of the guideline are required to disclose all such current relationships, as well as those existing 12 months previously. In December 2009, the ACCF and AHA implemented a new policy for relationships with industry and other entities (RWI) that requires the writing committee chair plus a minimum of 50% of the writing committee to have no relevant RWI (Appendix 1 for the ACCF/AHA definition of relevance). These statements are reviewed by the Task Force and all members during each conference call and meeting of the writing committee and are updated as changes occur. All guideline recommendations require a confidential vote by the writing committee and must be approved by a consensus of the voting members. Members are not permitted to write, and must recuse themselves from voting on, any recommendation or section to which their RWI apply. Members who recused themselves from voting are indicated in the list of writing committee members, and section recusals are noted in Appendix 1. Authors' and peer reviewers' RWI pertinent to this guideline are disclosed in Appendixes 1 and 2, respectively.

Additionally, to ensure complete transparency, writing committee members' comprehensive disclosure information—including RWI not pertinent to this document—is available as an online supplement. Comprehensive disclosure information for the Task Force is also available online at www.cardiosource.org/ACC/About-ACC/Leadership/Guidelines-and-Documents-Task-Forces.aspx. The work of the writing committee was supported exclusively by the ACCF and AHA without commercial support. Writing committee members volunteered their time for this activity.

In an effort to maintain relevance at the point of care for practicing physicians, the Task Force continues to oversee an ongoing process improvement initiative. As a result, in response to pilot projects, evidence tables (with references linked to abstracts in PubMed) have been added.

In April 2011, the Institute of Medicine released 2 reports: *Finding What Works in Health Care: Standards for Systematic Reviews* and *Clinical Practice Guidelines We Can Trust* (2,3). It is noteworthy that the ACCF/AHA guidelines are cited as being compliant with many of the proposed standards. A thorough review of these reports and of our current methodology is under way, with further enhancements anticipated.

The recommendations in this guideline are considered current until they are superseded by a focused update or the full-text guideline is revised. Guidelines are official policy of both the ACCF and AHA.

Alice K. Jacobs, MD, FACC, FAHA Chair
ACCF/AHA Task Force on Practice Guidelines

1. Introduction

1.1. Methodology and Evidence Review

Whenever possible, the recommendations listed in this document are evidence based. Articles reviewed in this guideline revision covered evidence from the past 10 years through January 2011, as well as selected other references through April 2011. Searches were limited to studies, reviews, and other evidence conducted in human subjects that were published in English. Key search words included but were not limited to the following: *analgesia*, *anastomotic techniques*, *antiplatelet agents*, *automated proximal clampless anastomosis device*, *asymptomatic ischemia*, *Cardica C-port*, *cost effectiveness*, *depressed left ventricular (LV) function*, *distal anastomotic techniques*, *direct proximal anastomosis on aorta*, *distal anastomotic devices*, *emergency coronary artery bypass graft (CABG) and ST-elevation myocardial infarction (STEMI)*, *heart failure*, *interrupted sutures*, *LV systolic dysfunction, magnetic connectors*, *PAS-Port automated proximal clampless anastomotic device*, *patency*, *proximal connectors*, *renal disease*, *sequential anastomosis*, *sternotomy*, *symmetry connector*, *symptomatic ischemia*, *proximal connectors*, *sequential anastomosis*, *T grafts*, *thoracotomy*, *U-clips*, *Ventrica Magnetic Vascular Port system*, *Y grafts*. Additionally, the committee reviewed documents related to the subject matter previously published by the

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ACCF and AHA. References selected and published in this document are representative but not all-inclusive.

To provide clinicians with a comprehensive set of data, whenever deemed appropriate or when published, the absolute risk difference and number needed to treat or harm are provided in the guideline, along with confidence interval (CI) and data related to the relative treatment effects such as odds ratio (OR), relative risk (RR), hazard ratio (HR), or incidence rate ratio.

The focus of these guidelines is the safe, appropriate, and efficacious performance of CABG.

1.2. Organization of the Writing Committee

The committee was composed of acknowledged experts in CABG, interventional cardiology, general cardiology, and cardiovascular anesthesiology. The committee included representatives from the ACCF, AHA, American Association for Thoracic Surgery, Society of Cardiovascular Anesthesiologists, and Society of Thoracic Surgeons (STS).

1.3. Document Review and Approval

This document was reviewed by 2 official reviewers, each nominated by both the ACCF and the AHA, as well as 1 reviewer each from the American Association for Thoracic Surgery, Society of Cardiovascular Anesthesiologists, and STS, as well as members from the ACCF/AHA Task Force on Data Standards, ACCF/AHA Task Force on Performance Measures, ACCF Surgeons' Scientific Council, ACCF Interventional Scientific Council, and Southern Thoracic Surgical Association. All information on reviewers' RWI was distributed to the writing committee and is published in this document (Appendix 2).

This document was approved for publication by the governing bodies of the ACCF and the AHA and endorsed by the American Association for Thoracic Surgery, Society of Cardiovascular Anesthesiologists, and STS.

2. Procedural Considerations

2.1. Intraoperative Considerations

2.1.1. Anesthetic Considerations: Recommendations

CLASS I

1. Anesthetic management directed toward early postoperative extubation and accelerated recovery of low- to medium-risk patients undergoing uncomplicated CABG is recommended (4–6). *(Level of Evidence: B)*
2. Multidisciplinary efforts are indicated to ensure an optimal level of analgesia and patient comfort throughout the perioperative period (7–11). *(Level of Evidence: B)*
3. Efforts are recommended to improve interdisciplinary communication and patient safety in the perioperative environment (e.g., formalized checklist-guided multidisciplinary communication) (12–15). *(Level of Evidence: B)*
4. A fellowship-trained cardiac anesthesiologist (or experienced board-certified practitioner) credentialed in the use of perioperative transesophageal echocardiography (TEE) is recommended to provide or supervise anesthetic care of patients who are considered to be at high risk (16–18). *(Level of Evidence: C)*

CLASS IIa

1. Volatile anesthetic-based regimens can be useful in facilitating early extubation and reducing patient recall (5,19–21). *(Level of Evidence: A)*

CLASS IIb

1. The effectiveness of high thoracic epidural anesthesia/analgesia for routine analgesic use is uncertain (22–25). *(Level of Evidence: B)*

CLASS III: HARM

1. Cyclooxygenase-2 inhibitors are not recommended for pain relief in the postoperative period after CABG (26,27). *(Level of Evidence: B)*
2. Routine use of early extubation strategies in facilities with limited backup for airway emergencies or advanced respiratory support is potentially harmful. *(Level of Evidence: C)*

See Online Data Supplement 1 for additional data on anesthetic considerations.

Anesthetic management of the CABG patient mandates a favorable balance of myocardial oxygen supply and demand to prevent or minimize myocardial injury (Section 2.1.8). Historically, the popularity of several anesthetic techniques for CABG has varied on the basis of their known or potential adverse cardiovascular effects (e.g., cardiovascular depression with high doses of volatile anesthesia, lack of such depression with high-dose opioids, or coronary vasodilation and concern for a "steal" phenomenon with isoflurane) as well as concerns about interactions with preoperative medications (e.g., cardiovascular depression with beta blockers or hypotension with angiotensin-converting enzyme [ACE] inhibitors and angiotensin-receptor blockers [ARBs] [28–30]) (Sections 2.1.8 and 4.5). Independent of these concerns, efforts to improve outcomes and to reduce costs have led to shorter periods of postoperative mechanical ventilation and even, in some patients, to prompt extubation in the operating room ("accelerated recovery protocols" or "fast-track management") (5,31).

High-dose opioid anesthesia with benzodiazepine supplementation was used commonly in CABG patients in the United States in the 1970s and 1980s. Subsequently, it became clear that volatile anesthetics are protective in the setting of myocardial ischemia and reperfusion, and this, in combination with a shift to accelerated recovery or "fast-track" strategies, led to their ubiquitous use. As a result, opioids have been relegated to an adjuvant role (32,33). Despite their widespread use, volatile anesthetics have not been shown to provide a mortality rate advantage when compared with other intravenous regimens (Section 2.1.8).

Optimal anesthesia care in CABG patients should include 1) a careful preoperative evaluation and treatment of modifiable risk factors; 2) proper handling of all medications given preoperatively (Sections 4.1, 4.3, and 4.5); 3) establishment of central venous access and careful cardiovascular monitoring; 4) induction of a state of unconsciousness, analgesia, and immobility; and 5) a smooth transition to the

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early postoperative period, with a goal of early extubation, patient mobilization, and hospital discharge. Attention should be directed at preventing or minimizing adverse hemodynamic and hormonal alterations that may induce myocardial ischemia or exert a deleterious effect on myocardial metabolism (as may occur during cardiopulmonary bypass [CPB]) (Section 2.1.8). This requires close interaction between the anesthesiologist and surgeon, particularly when manipulation of the heart or great vessels is likely to induce hemodynamic instability. During on-pump CABG, particular care is required during vascular cannulation and weaning from CPB; with off-pump CABG, the hemodynamic alterations often caused by displacement or verticalization of the heart and application of stabilizer devices on the epicardium, with resultant changes in heart rate, cardiac output, and systemic vascular resistance, should be monitored carefully and managed appropriately.

In the United States, nearly all patients undergoing CABG receive general anesthesia with endotracheal intubation utilizing volatile halogenated general anesthetics with opioid supplementation. Intravenous benzodiazepines often are given as premedication or for induction of anesthesia, along with other agents such as propofol or etomidate. Nondepolarizing neuromuscular-blocking agents, particularly nonvagolytic agents with intermediate duration of action, are preferred to the longer-acting agent, pancuronium. Use of the latter is associated with higher intraoperative heart rates and a higher incidence of residual neuromuscular depression in the early postoperative period, with a resultant delay in extubation (23,34). In addition, low concentrations of volatile anesthetic usually are administered via the venous oxygenator during CPB, facilitating amnesia and reducing systemic vascular resistance.

Outside the United States, alternative anesthetic techniques, particularly total intravenous anesthesia via propofol and opioid infusions with benzodiazepine supplementation with or without high thoracic epidural anesthesia, are commonly used. The use of high thoracic epidural anesthesia exerts salutary effects on the coronary circulation as well as myocardial and pulmonary function, attenuates the stress response, and provides prolonged postoperative analgesia (24,25,35). In the United States, however, concerns about the potential for neuraxial bleeding (particularly in the setting of heparinization, platelet inhibitors, and CPB-induced thrombocytopenia), local anesthetic toxicity, and logistical issues related to the timing of epidural catheter insertion and management have resulted in limited use of these techniques (22). Their selective use in patients with severe pulmonary dysfunction (Section 6.5) or chronic pain syndromes may be considered. Although meta-analyses of randomized controlled trials (RCTs) of high thoracic epidural anesthesia/analgesia in CABG patients (particularly on-pump) have yielded inconsistent results on morbidity and mortality rates, it does appear to reduce time to extubation, pain, and pulmonary complications (36–38). Of interest, although none of the RCTs have reported the occurrence of epidural hematoma or abscess, these entities occur on occasion (38). Finally, the use of other regional anesthetic approaches for postoperative analgesia, such as parasternal block, has been reported (39).

Over the past decade, early extubation strategies ("fast-track" anesthesia) often have been used in low- to medium-risk CABG patients. These strategies allow a shorter time to extubation, a decreased length of intensive care unit (ICU) stay, and variable effects on length of hospital stay (4–6). Immediate extubation in the operating room, with or without markedly accelerated postoperative recovery pathways (e.g., "ultra-fast-tracking," "rapid recovery protocol," "short-stay intensive care") have been used safely, with low rates of reintubation and no influence on quality of life (40–44). Observational data suggest that physician judgment in triaging lower-risk patients to early or immediate extubation works well, with rates of reintubation <1% (45). Certain factors appear to predict fast-track "failure," including previous cardiac surgery, use of intra-aortic balloon counterpulsation, and possibly advanced patient age.

Provision of adequate perioperative analgesia is important in enhancing patient mobilization, preventing pulmonary complications, and improving the patient's psychological well-being (9,11). The intraoperative use of high-dose morphine (40 mg) may offer superior postoperative pain relief and enhance patient well-being compared with fentanyl (despite similar times to extubation) (46).

The safety of nonsteroidal anti-inflammatory agents for analgesia is controversial, with greater evidence for adverse cardiovascular events with the selective cyclooxygenase-2 inhibitors than the nonselective agents. A 2007 AHA scientific statement presented a stepped-care approach to the management of musculoskeletal pain in patients with or at risk for coronary artery disease (CAD), with the goal of limiting the use of these agents to patients in whom safer therapies fail (47). In patients hospitalized with unstable angina (UA) and non–ST-elevation myocardial infarction (NSTEMI), these agents should be discontinued promptly and reinstituted later according to the stepped-care approach (48).

In the setting of cardiac surgery, nonsteroidal anti-inflammatory agents previously were used for perioperative analgesia. A meta-analysis of 20 trials of patients undergoing thoracic or cardiac surgery, which evaluated studies published before 2005, reported significant reductions in pain scores, with no increase in adverse outcomes (49). Subsequently, 2 RCTs, both studying the oral cyclooxygenase-2 inhibitor valdecoxib and its intravenous prodrug, parecoxib, reported a higher incidence of sternal infections in 1 trial and a significant increase in adverse cardiovascular events in the other (26,27). On the basis of the results of these 2 studies (as well as other nonsurgical reports of increased risk with cyclooxygenase-2–selective agents), the U.S. Food and Drug Administration in 2005 issued a "black box" warning for all nonsteroidal anti-inflammatory agents (except aspirin) immediately after CABG (50). The concurrent administration

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of ibuprofen with aspirin has been shown to attenuate the latter's inhibition of platelet aggregation, likely because of competitive inhibition of cyclooxygenase at the platelet-receptor binding site (51).

Observational analyses in patients undergoing noncardiac surgery have shown a significant reduction in perioperative death with the use of checklists, multidisciplinary surgical care, intraoperative time-outs, postsurgical debriefings, and other communication strategies (14,15). Such methodology is being used increasingly in CABG patients (12–14).

In contrast to extensive literature on the role of the surgeon in determining outcomes with CABG, limited data on the influence of the anesthesiologist are available. Of 2 such reports from single centers in the 1980s, 1 suggested that the failure to control heart rate to ≤110 beats per minute was associated with a higher mortality rate, and the other suggested that increasing duration of CPB adversely influenced outcome (52,53). Another observational analysis of data from vascular surgery patients suggested that anesthetic specialization was independently associated with a reduction in mortality rate (54).

To meet the challenges of providing care for the increasingly higher-risk patients undergoing CABG, efforts have been directed at enhancing the experience of trainees, particularly in the use of newer technologies such as TEE. Cardiac anesthesiologists, in collaboration with cardiologists and surgeons, have implemented national training and certification processes for practitioners in the use of perioperative TEE (Section 2.1.7) (164,165). Accreditation of cardiothoracic anesthesia fellowship programs from the Accreditation Council for Graduate Medical Education was initiated in 2004, and efforts are ongoing to obtain formal subspecialty certification (18).

2.1.2. Use of CPB

Several adverse outcomes have been attributed to CPB, including 1) neurological deficits (e.g., stroke, coma, postoperative neurocognitive dysfunction); 2) renal dysfunction; and 3) the Systemic Inflammatory Response Syndrome (SIRS). The SIRS is manifested as generalized systemic inflammation occurring after a major morbid event, such as trauma, infection, or major surgery. It is often particularly apparent after on-pump cardiac surgery, during which surgical trauma, contact of blood with nonphysiological surfaces (e.g., pump tubing, oxygenator surfaces), myocardial ischemia and reperfusion, and hypothermia combine to cause a dramatic release of cytokines (e.g., interleukin [IL] 6 and IL8) and other mediators of inflammation (55). Some investigators have used serum concentrations of S100 beta as a marker of brain injury (56) and have correlated increased serum levels with the number of microemboli exiting the CPB circuit during CABG. In contrast, others have noted the increased incidence of microemboli with on-pump CABG (relative to off-pump CABG) but have failed to show a corresponding worsening of neurocognitive function 1 week to 6 months postoperatively (57,58). Blood retrieved from the operative field during on-pump CABG contains lipid material and particulate matter, which have been implicated as possible causes of postoperative neurocognitive dysfunction. Although a study (59) reported that CPB-associated neurocognitive dysfunction can be mitigated by the routine processing of shed blood with a cell saver before its reinfusion, another study (60) failed to show such an improvement.

It has been suggested that CPB leads to an increased incidence of postoperative renal failure requiring dialysis, but a large RCT comparing on-pump and off-pump CABG showed no difference in its occurrence (61). Of interest, this study failed to show a decreased incidence of postoperative adverse neurological events (stroke, coma, or neurocognitive deficit) in those undergoing off-pump CABG.

The occurrence of SIRS in patients undergoing CPB has led to the development of strategies designed to prevent or to minimize its occurrence. Many reports have focused on the increased serum concentrations of cytokines (e.g., IL-2R, IL-6, IL-8, tumor necrosis factor alpha) and other modulators of inflammation (e.g., P-selectin, sE-selectin, soluble intercellular adhesion molecule-1, plasma endothelial cell adhesion molecule-1, and plasma malondialdehyde), which reflect leukocyte and platelet activation, in triggering the onset of SIRS. A study showed a greater upregulation of neutrophil CD11b expression (a marker of leukocyte activation) in patients who sustained a ≥50% increase in the serum creatinine concentration after CPB, thereby implicating activated neutrophils in the pathophysiology of SIRS and the occurrence of post-CPB renal dysfunction (62). Modulating neutrophil activation to reduce the occurrence of SIRS has been investigated; however, the results have been inconsistent. Preoperative intravenous methylprednisolone (10 mg/kg) caused a reduction in the serum concentrations of many of these cytokines after CPB, but this reduction was not associated with improved hemodynamic variables, diminished blood loss, less use of inotropic agents, shorter duration of ventilation, or shorter ICU length of stay (63). Similarly, the use of intravenous immunoglobulin G in patients with post-CPB SIRS has not been associated with decreased rates of short-term morbidity or 28-day mortality (64).

Other strategies to mitigate the occurrence of SIRS after CPB have been evaluated, including the use of 1) CPB circuits (including oxygenators) coated with materials known to reduce complement and leukocyte activation; 2) CPB tubing that is covalently bonded to heparin; and 3) CPB tubing coated with polyethylene oxide polymer or Poly (2-methoxyethylacrylate). Leukocyte depletion via specialized filters in the CPB circuits has been shown to reduce the plasma concentrations of P-selectin, intercellular adhesion molecule-1, IL-8, plasma endothelial cell adhesion molecule-1, and plasma malondialdehyde after CPB (65).

Finally, closed mini-circuits for CPB have been developed in an attempt to minimize the blood–air interface and blood contact with nonbiological surfaces, both of which

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promote cytokine elaboration, but it is uncertain if these maneuvers and techniques have a discernible effect on outcomes after CABG.

2.1.3. Off-Pump CABG Versus Traditional On-Pump CABG

Since the first CABG was performed in the late 1960s, the standard surgical approach has included the use of cardiac arrest coupled with CPB (so-called on-pump CABG), thereby optimizing the conditions for construction of vascular anastomoses to all diseased coronary arteries without cardiac motion or hemodynamic compromise. Such on-pump CABG has become the gold standard and is performed in about 80% of subjects undergoing the procedure in the United States. Despite the excellent results that have been achieved, the use of CPB and the associated manipulation of the ascending aorta are linked with certain perioperative complications, including myonecrosis during aortic occlusion, cerebrovascular accidents, generalized neurocognitive dysfunction, renal dysfunction, and SIRS. In an effort to avoid these complications, off-pump CABG was developed (58,66). Off-pump CABG is performed on the beating heart with the use of stabilizing devices (which minimize cardiac motion); in addition, it incorporates techniques to minimize myocardial ischemia and systemic hemodynamic compromise. As a result, the need for CPB is obviated. This technique does not necessarily decrease the need for manipulation of the ascending aorta during construction of the proximal anastomoses.

To date, the results of several RCTs comparing on-pump and off-pump CABG in various patient populations have been published (61,67,68). In addition, registry data and the results of meta-analyses have been used to assess the relative efficacies of the 2 techniques (69,70). In 2005, an AHA scientific statement comparing the 2 techniques concluded that both procedures usually result in excellent outcomes and that neither technique should be considered superior to the other (71). At the same time, several differences were noted. Off-pump CABG was associated with less bleeding, less renal dysfunction, a shorter length of hospital stay, and less neurocognitive dysfunction. The incidence of perioperative stroke was similar with the 2 techniques. On-pump CABG was noted to be less technically complex and allowed better access to diseased coronary arteries in certain anatomic locations (e.g., those on the lateral LV wall) as well as better long-term graft patency.

In 2009, the results of the largest RCT to date comparing on-pump CABG to off-pump CABG, the ROOBY (Randomized On/Off Bypass) trial, were published, reporting the outcomes for 2,203 patients (99% men) at 18 Veterans Affairs Medical Centers (61). The primary short-term endpoint, a composite of death or complications (reoperation, new mechanical support, cardiac arrest, coma, stroke, or renal failure) within 30 days of surgery, occurred with similar frequency (5.6% for on-pump CABG; 7.0% for off-pump CABG; $p=0.19$). The primary long-term endpoint, a composite of death from any cause, a repeat revascularization procedure, or a nonfatal myocardial infarction (MI) within 1 year of surgery, occurred more often in those undergoing off-pump CABG (9.9%) than in those having on-pump CABG (7.4%; $p=0.04$). Neuropsychological outcomes and resource utilization were similar between the 2 groups. One year after surgery, graft patency was higher in the on-pump group (87.8% versus 82.6%; $p<0.01$). In short, the ROOBY investigators failed to show an advantage of off-pump CABG compared with on-pump CABG in a patient population considered to be at low risk. Instead, use of the on-pump technique was associated with better 1-year composite outcomes and 1-year graft patency rates, with no difference in neuropsychological outcomes or resource utilization.

Although numerous investigators have used single-center registries, the STS database, and meta-analyses in an attempt to identify patient subgroups in whom off-pump CABG is the preferred procedure, even these analyses have reached inconsistent conclusions about off-pump CABG's ability to reduce morbidity and mortality rates (69,72–83). A retrospective cohort study of 14,766 consecutive patients undergoing isolated CABG identified a mortality benefit (OR: 0.45) for off-pump CABG in patients with a predicted risk of mortality >2.5% (82), but a subsequent randomized comparison of off-pump CABG to traditional on-pump CABG in 341 high-risk patients (a Euroscore >5) showed no difference in the composite endpoint of all-cause death, acute MI, stroke, or a required reintervention procedure (78). An analysis of data from the New York State Cardiac Surgery Reporting system did not demonstrate a reduction in mortality rate with off-pump CABG in any patient subgroup, including the elderly (age >80 years) or those with cerebrovascular disease, azotemia, or an extensively calcified ascending aorta (69).

Despite these results, off-pump CABG is the preferred approach by some surgeons who have extensive experience with it and therefore are comfortable with its technical nuances. Recently, published data suggested that the avoidance of aortic manipulation is the most important factor in reducing the risk of neurological complications (84,85). Patients with extensive disease of the ascending aorta pose a special challenge for on-pump CABG; for these patients, cannulation or cross-clamping of the aorta may create an unacceptably high risk of stroke. In such individuals, off-pump CABG in conjunction with avoidance of manipulation of the ascending aorta (including placement of proximal anastomoses) may be beneficial. Surgeons typically prefer an on-pump strategy in patients with hemodynamic compromise because CPB offers support for the systemic circulation. In the end, most surgeons consider either approach to be reasonable for the majority of subjects undergoing CABG.

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2.1.4. Bypass Graft Conduit: Recommendations

CLASS I

1. If possible, the left internal mammary artery (LIMA) should be used to bypass the left anterior descending (LAD) artery when bypass of the LAD artery is indicated (86–89). *(Level of Evidence: B)*

CLASS IIa

1. The right internal mammary artery (IMA) is probably indicated to bypass the LAD artery when the LIMA is unavailable or unsuitable as a bypass conduit. *(Level of Evidence: C)*
2. When anatomically and clinically suitable, use of a second IMA to graft the left circumflex or right coronary artery (when critically stenosed and perfusing LV myocardium) is reasonable to improve the likelihood of survival and to decrease reintervention (90–94). *(Level of Evidence: B)*

CLASS IIb

1. Complete arterial revascularization may be reasonable in patients less than or equal to 60 years of age with few or no comorbidities. *(Level of Evidence: C)*
2. Arterial grafting of the right coronary artery may be reasonable when a critical (≥90%) stenosis is present (89,93,95). *(Level of Evidence: B)*
3. Use of a radial artery graft may be reasonable when grafting left-sided coronary arteries with severe stenoses (>70%) and right-sided arteries with critical stenoses (≥90%) that perfuse LV myocardium (96–101). *(Level of Evidence: B)*

CLASS III: HARM

1. An arterial graft should not be used to bypass the right coronary artery with less than a critical stenosis (<90%) (89). *(Level of Evidence: C)*

Arteries (internal mammary, radial, gastroepiploic, and inferior epigastric) or veins (greater and lesser saphenous) may be used as conduits for CABG. The effectiveness of CABG in relieving symptoms and prolonging life is directly related to graft patency. Because arterial and venous grafts have different patency rates and modes of failure, conduit selection is important in determining the long-term efficacy of CABG.

2.1.4.1. SAPHENOUS VEIN GRAFTS

Reversed saphenous vein grafts (SVGs) are commonly used in patients undergoing CABG. Their disadvantage is a declining patency with time: 10% to as many as 25% of them occlude within 1 year of CABG (89,102,103); an additional 1% to 2% occlude each year during the 1 to 5 years after surgery; and 4% to 5% occlude each year between 6 and 10 years postoperatively (104). Therefore, 10 years after CABG, 50% to 60% of SVGs are patent, only half of which have no angiographic evidence of atherosclerosis (104). During SVG harvesting and initial exposure to arterial pressure, the endothelium often is damaged, which, if extensive, may lead to platelet aggregation and graft thrombosis. Platelet adherence to the endothelium begins the process of intimal hyperplasia that later causes SVG atherosclerosis (103,105). After adhering to the intima, the platelets release mitogens that stimulate smooth muscle cell migration, leading to intimal proliferation and hyperplasia. Lipid is incorporated into these areas of intimal hyperplasia, resulting in atherosclerotic plaque formation (106). The perioperative administration of aspirin and dipyridamole improves early (<1 month) and 1-year SVG patency and decreases lipid accumulation in the SVG intima (103, 106,107).

2.1.4.2. INTERNAL MAMMARY ARTERIES

Unlike SVGs, IMAs usually are patent for many years postoperatively (10-year patency >90%) (89,95,102,108–117) because of the fact that <4% of IMAs develop atherosclerosis, and only 1% have atherosclerotic stenoses of hemodynamic significance (118–120). This resistance to the development of atherosclerosis is presumably due to 1) the nearly continuous internal elastic lamina that prevents smooth muscle cell migration and 2) the release of prostacyclin and nitric oxide, potent vasodilators and inhibitors of platelet function, by the endothelium of IMAs (119,121,122).

The disadvantage of using the IMA is that it may spasm and eventually atrophy if used to bypass a coronary artery without a flow-limiting stenosis (89,95,118,123–130). Observational studies suggest an improved survival rate in patients undergoing CABG when the LIMA (rather than an SVG) is used to graft the LAD artery (86–88); this survival benefit is independent of the patient's sex, age, extent of CAD, and LV systolic function (87,88). Apart from improving survival rate, LIMA grafting of the LAD artery reduces the incidence of late MI, hospitalization for cardiac events, need for reoperation, and recurrence of angina (86,88). The LIMA should be used to bypass the LAD artery provided that a contraindication to its use (e.g., emergency surgery, poor LIMA blood flow, subclavian artery stenosis, radiation injury, atherosclerosis) is not present.

Because of the beneficial influence on morbidity and mortality rates of using the IMA for grafting, several centers have advocated bilateral IMA grafting in hopes of further improving CABG results (90,91,94). In fact, numerous observational studies have demonstrated improved morbidity and mortality rates when both IMAs are used. On the other hand, bilateral IMA grafting appears to be associated with an increased incidence of sternal wound infections in patients with diabetes mellitus and those who are obese (body mass index >30 kg/m^2).

2.1.4.3. RADIAL, GASTROEPIPLOIC, AND INFERIOR EPIGASTRIC ARTERIES

Ever since the observation that IMAs are superior to SVGs in decreasing the occurrence of ischemic events and prolonging survival, other arterial conduits, such as the radial, gastroepiploic, and inferior epigastric arteries, have been used in an attempt to improve the results of CABG. Information about these other arterial conduits is sparse in comparison to what is known about IMAs and SVGs, however. The radial artery is a muscular artery that is susceptible to spasm and atrophy when used to graft a coronary artery that is not severely narrowed. Radial artery

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graft patency is best when used to graft a left-sided coronary artery with >70% stenosis and worst when it is used to bypass the right coronary artery with a stenosis of only moderate severity (96–100).

The gastroepiploic artery is most often used to bypass the right coronary artery or its branches, although it may be used to bypass the LAD artery if the length of the gastroepiploic artery is adequate. Similar to the radial artery, it is prone to spasm and therefore should only be used to bypass coronary arteries that are severely stenotic (131). The 1-, 5-, and 10-year patency rates of the gastroepiploic artery are reportedly 91%, 80%, and 62%, respectively (132).

The inferior epigastric artery is only 8 to 10 centimeters in length and therefore is usually used as a "Y" or "T" graft connected to another arterial conduit. On occasion it is used as a free graft from the aorta to a high diagonal branch of the LAD artery. Because it is a muscular artery, it is prone to spasm and therefore is best used to bypass a severely stenotic coronary artery. Its reported 1-year patency is about 90% (133,134).

2.1.5. Incisions for Cardiac Access

Although the time-honored incision for CABG is a median sternotomy, surgeons have begun to access the heart via several other approaches in an attempt to 1) reduce the traumatic effects often seen with full median sternotomy, 2) hasten postoperative recovery, and 3) enhance cosmesis. The utility and benefit of these smaller incisions has been evident in subjects undergoing valvular surgery, for which only limited access to the heart is required.

The most minimally invasive access incisions for CABG are seen with robotically assisted totally endoscopic CABG. A study showed that totally endoscopic CABG with robotic technology was associated with improved physical health, shorter hospital stay, and a more rapid return to the activities of daily living compared with traditional techniques. At present, direct comparisons of robotically assisted and conventional CABG are lacking (135).

The use of minimally invasive cardiac access incisions for CABG is limited. The need for adequate exposure of the ascending aorta and all surfaces of the heart to accomplish full revascularization usually precludes the use of minimal access incisions, such as upper sternotomy, lower sternotomy, or anterolateral thoracotomy. Nevertheless, use of limited incisions may increase in the future with the advent of hybrid strategies that use a direct surgical approach (usually for grafting the LAD artery through a small parasternal incision) and percutaneous coronary intervention (PCI) of the other diseased coronary arteries. The benefit of hybrid revascularization and hybrid operating rooms, in which PCI and CABG can be accomplished in one procedure, is yet to be determined. In patients with certain comorbid conditions, such as severe aortic calcification, previous chest irradiation, and obesity in combination with severe diabetes mellitus, full median sternotomy may be problematic (136), and hybrid revascularization may be preferable.

2.1.6. Anastomotic Techniques

At present, most coronary bypass grafts are constructed with hand-sewn suture techniques for the proximal and distal anastomoses, a practice that has resulted in good short- and intermediate-term patency rates. Because surgeons have different preferences with regard to the technical aspects of the procedure, a wide variety of suture configurations is used. Sewing of the proximal and distal anastomoses with a continuous polypropylene suture is commonly done, but techniques with interrupted silk sutures have been used, with similar results for graft patency and adverse events.

Certain clinical scenarios have precipitated an interest in alternative techniques of constructing coronary bypass anastomoses. Some surgeons and patients wish to avoid the potential morbidity and cosmetic results of a median sternotomy, yet the least invasive incisions usually are too small to allow hand-sewn anastomoses. To solve this problem, coronary connector devices have been developed for use with arterial or venous conduits to enable grafting without direct suturing. In addition, these devices have been used in subjects with diseased ascending aortas, in whom a technique that allows construction of a proximal anastomosis with minimal manipulation of the ascending aorta (typically by eliminating the need for aortic cross-clamping) may result in less embolization of debris, thereby reducing the occurrence of adverse neurological outcomes. In this situation, the operation is performed through a median sternotomy, and the proximal anastomoses are created with a connector (or may be hand-sewn with the assistance of a device that provides a bloodless operative field) without partial or complete clamping of the ascending aorta.

2.1.7. Intraoperative TEE: Recommendations

CLASS I

1. Intraoperative TEE should be performed for evaluation of acute, persistent, and life-threatening hemodynamic disturbances that have not responded to treatment (137,138). *(Level of Evidence: B)*
2. Intraoperative TEE should be performed in patients undergoing concomitant valvular surgery (137,139). *(Level of Evidence: B)*

CLASS IIa

1. Intraoperative TEE is reasonable for monitoring of hemodynamic status, ventricular function, regional wall motion, and valvular function in patients undergoing CABG (138,140–145). *(Level of Evidence: B)*

The use of intraoperative TEE in patients undergoing cardiac surgery has increased steadily since its introduction in the late 1980s. Although its utility is considered to be highest in patients undergoing valvular and complex open great-vessel/aortic surgery, it is commonly used in subjects undergoing CABG. TEE is most often used (146), although epicardial and epiaortic imaging, performed under aseptic conditions, allows visualization of imaging planes not possible with TEE (147,148). Specifically, epiaortic

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imaging allows visualization of the "blind spot" of the ascending aorta (caused by interposition of the trachea with the esophagus), the site of aortic cannulation for CPB, from which dislodgement of friable atheroma, a major risk factor for perioperative stroke, may occur (Section 5.2.1). In addition, epicardial probes allow imaging when TEE is contraindicated, cannot be performed, or produces inadequate images. It can facilitate the identification of intraventricular thrombi when TEE images are equivocal.

The "2003 ACC/AHA/ASE Guideline Update for the Clinical Application of Echocardiography" based its recommendations on those reported in the 1996 American Society of Anesthesiologists/Society of Cardiovascular Anesthesiologists practice guideline and considered the use of TEE in CABG patients (149). The latter document was updated in 2010 (139). Because of the use of different grading methodologies in the American Society of Anesthesiologists/Society of Cardiovascular Anesthesiologists guideline relative to that of the ACCF/AHA, precise comparisons are difficult. However, it is noted that TEE "should be considered" in subjects undergoing CABG, to confirm and refine the preoperative diagnosis, detect new or unsuspected pathology, adjust the anesthetic and surgical plan accordingly, and assess the results of surgery. The strongest recommendation is given for treatment of acute life-threatening hemodynamic instability that has not responded to conventional therapies.

Observational cohort analyses and case reports have suggested the utility of TEE for diagnosing acute life-threatening hemodynamic or surgical problems in CABG patients, many of which are difficult or impossible to detect or treat without direct imaging. Evaluation of ventricular cross-sectional areas and ejection fraction (EF) and estimation or direct measurement of cardiac output by TEE may facilitate anesthetic, fluid, and inotropic/pressor management. The utility of echocardiography for the evaluation of LV end-diastolic area/volume and its potential superiority over pulmonary artery occlusion or pulmonary artery diastolic pressure, particularly in the early postoperative period, has been reported (150,151) (Section 4.10). In subjects without preoperative transthoracic imaging, intraoperative TEE may provide useful diagnostic information (over and above that detected during cardiac catheterization) on valvular function as well as evidence of pulmonary hypertension, intracardiac shunts, or other complications that may alter the planned surgery.

In patients undergoing CABG, intraoperative TEE is used most often for the detection of regional wall motion abnormalities (possibly caused by myocardial ischemia or infarction) and their effect on LV function. Observational studies have suggested that regional wall motion abnormalities detected with TEE can guide surgical therapy, leading to revision of a failed or inadequate conduit or the placement of additional grafts not originally planned. The presence of new wall motion abnormalities after CPB correlates with adverse perioperative and long-term outcomes (143).

Although the initial hope that an estimation of coronary blood flow with intramyocardial contrast enhancement visualized by TEE would facilitate surgical intervention has not been realized, technical advances in imaging of coronary arteries and grafts may ultimately provide reliable information. At present, the evaluation of graft flow with conventional nonimaging handheld Doppler probes appears adequate (Section 8). Intraoperative evaluation of mitral regurgitation may facilitate detection of myocardial ischemia and provide guidance about the need for mitral valve annuloplasty (Section 6.7). Newer technologies, including nonimaging methods for analyzing systolic and diastolic velocity and direction and timing of regional wall motion (Doppler tissue imaging and speckle tracking), as well as "real-time" 3-dimensional imaging, may facilitate the diagnosis of myocardial ischemia and evaluation of ventricular function. At present, however, their cost-effectiveness has not been determined, and they are too complex for routine use (152–154).

Among different centers, the rate of intraoperative TEE use in CABG patients varies from none to routine; its use is influenced by many factors, such as institutional and practitioner preferences, the healthcare system and reimbursement strategies, tertiary care status, and presence of training programs (155). The efficacy of intraoperative TEE is likely influenced by the presence of 1) LV systolic and diastolic dysfunction, 2) concomitant valvular disease, 3) the planned surgical procedure (on pump versus off pump, primary versus reoperative), 4) the surgical approach (full sternotomy versus partial sternotomy versus endoscopic or robotic), 5) its acuity (elective versus emergency); and 6) physician training and experience (137,138,140–142,144,145,156–163).

The safety of intraoperative TEE in patients undergoing cardiac surgery is uncertain. Retrospective analyses of data from patients undergoing diagnostic upper gastrointestinal endoscopy, nonoperative diagnostic TEE imaging, and intraoperative imaging by skilled operators in high-volume centers demonstrate a low frequency of complications related to insertion or manipulation of the probe (164,165). Nevertheless, minor (primarily pharyngeal injury from probe insertion) and major (esophageal perforation, gastric bleeding, or late mediastinitis) complications are reported (166,167). A more indolent complication is that of acquired dysphagia and possible aspiration postoperatively. Although retrospective analyses of postoperative cardiac surgical patients with clinically manifest esophageal dysfunction have identified TEE use as a risk factor (168–170), such dysfunction also has been reported in subjects in whom TEE was not used (171). Advanced age, prolonged intubation, and neurological injury seem to be risk factors for its development. The significance of the incidental intraoperative detection and repair of a patent foramen ovale, a common occurrence, is controversial (172). A 2009 obser-

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vational analysis of 13,092 patients (25% isolated CABG; 29% CABG or other cardiac procedure), of whom 17% had a patent foramen ovale detected by TEE (28% of which were repaired), reported an increase in postoperative stroke in the patients who had patent foramen ovale repair (OR: 2.47; 95% CI: 1.02 to 6.0) with no improvement in long-term outcome (173).

2.1.8. Preconditioning/Management of Myocardial Ischemia: Recommendations

CLASS I

1. Management targeted at optimizing the determinants of coronary arterial perfusion (e.g., heart rate, diastolic or mean arterial pressure, and right ventricular or LV end-diastolic pressure) is recommended to reduce the risk of perioperative myocardial ischemia and infarction (53,174–177). *(Level of Evidence: B)*

CLASS IIa

1. Volatile-based anesthesia can be useful in reducing the risk of perioperative myocardial ischemia and infarction (178–181). *(Level of Evidence: A)*

CLASS IIb

1. The effectiveness of prophylactic pharmacological therapies or controlled reperfusion strategies aimed at inducing preconditioning or attenuating the adverse consequences of myocardial reperfusion injury or surgically induced systemic inflammation is uncertain (182–189). *(Level of Evidence: A)*
2. Mechanical preconditioning might be considered to reduce the risk of perioperative myocardial ischemia and infarction in patients undergoing off-pump CABG (190–192). *(Level of Evidence: B)*
3. Remote ischemic preconditioning strategies using peripheral-extremity occlusion/reperfusion might be considered to attenuate the adverse consequences of myocardial reperfusion injury (193–195). *(Level of Evidence: B)*
4. The effectiveness of postconditioning strategies to attenuate the adverse consequences of myocardial reperfusion injury is uncertain (196,197). *(Level of Evidence: C)*

See Online Data Supplements 2 to 4 for additional data on preconditioning.

Perioperative myocardial injury is associated with adverse outcomes after CABG (198–200), and available data suggest a direct correlation between the amount of myonecrosis and the likelihood of an adverse outcome (198,201–204) (Section 5.2.4).

The etiologies of perioperative myocardial ischemia and infarction and their complications (electrical or mechanical) range from alterations in the determinants of global or regional myocardial oxygen supply and demand to complex biochemical and microanatomic, systemic, or vascular abnormalities, many of which are not amenable to routine diagnostic and therapeutic interventions. Adequate surgical reperfusion is important in determining outcome, even though it may initially induce reperfusion injury. Various studies delineating the major mediators of reperfusion injury have focused attention on the mitochondrial permeability transition pore, the opening of which during reperfusion uncouples oxidative phosphorylation, ultimately leading to cell death (205). Although several pharmacological interventions targeting components of reperfusion injury have been tried, none has been found to be efficacious for this purpose (182,184–189,205–207).

The severity of reperfusion injury is influenced by numerous factors, including 1) the status of the patient's coronary circulation, 2) the presence of active ongoing ischemia or infarction, 3) preexisting medical therapy (Sections 4.3 and 4.5), 4) concurrent use of mechanical assistance to improve coronary perfusion (i.e., intra-aortic balloon counterpulsation), and 5) the surgical approach used (on pump or off pump). CPB with ischemic arrest is known to induce the release of cytokines and chemokines involved in cellular homeostasis, thrombosis, and coagulation; oxidative stress; adhesion of blood cell elements to the endothelium; and neuroendocrine stress responses; all of these may contribute to myocardial injury (208,209). Controlled reperfusion strategies during CPB, involving prolonged reperfusion with warm-blood cardioplegia in conjunction with metabolic enhancers, are rarely used in lieu of more routine methods of preservation (e.g., asystolic arrest, anterograde or retrograde blood cardioplegia during aortic cross-clamping). Several studies suggest that the magnitude of SIRS is greater with on-pump CABG than with off-pump CABG (201,208,210–213).

Initial studies of preconditioning used mechanical occlusion of arterial inflow followed by reperfusion via aortic cross-clamping immediately on institution of bypass or with coronary artery occlusion proximal to the planned distal anastomosis during off-pump CABG (190,191,214–217). Because of concerns of the potential adverse cerebral effects of aortic manipulation, enthusiasm for further study of this technique in on-pump CABG patients is limited (Section 5.2.1). Despite intense interest in the physiology of post-conditioning, few data are available (197). A small 2008 study in patients undergoing valve surgery, which used repeated manipulation of the ascending aorta, reported a reduction in surrogate markers of inflammation and myonecrosis (196). In lieu of techniques utilizing mechanical occlusion, pharmacological conditioning agents are likely to be used. An alternative approach that avoids much (but not all) of the safety concerns related to potential vascular injury is remote preconditioning of arterial inflow to the leg or (more commonly) the arm via blood pressure cuff occlusion (218). Two studies of patients undergoing on-pump CABG at a single center, the first of which used 2 different myocardial protection strategies and the second of which repeated the study with a standardized cold-blood cardioplegia routine, reported similar amounts of troponin release during the 72 hours postoperatively, with no apparent complications (193,195). A larger trial was unable to confirm any benefits of a similar protocol, casting doubt on the utility of this approach (194).

Volatile halogenated anesthetics and opioids have antiischemic or conditioning properties (32,33,219,220), and propofol has antioxidant properties of potential value in

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subjects with reperfusion injury (221,222). The salutary properties of volatile anesthetics during myocardial ischemia are well known. Their negative inotropic and chronotropic effects are considered to be beneficial, particularly in the setting of elevated adrenergic tone that is common with surgical stimulation. Although contemporary volatile agents demonstrate some degree of coronary arterial vasodilation (with isoflurane considered the most potent), the role of a "steal phenomena" in the genesis of ischemia is considered to be trivial (33). In comparison to propofol/opioid infusions, volatile agents seem to reduce troponin release, preserve myocardial function, and improve resource utilization (i.e., ICU or hospital lengths of stay) and 1-year outcome (223–227). It is postulated that multiple factors that influence myocardial preservation modulate the potential impact of a specific anesthetic regimen.

Observational analyses have reported an association between elevated perioperative heart rates and adverse outcomes (228,229), but it is difficult to recommend a specific heart rate for all CABG patients. Instead, the heart rate may need to be adjusted up or down to maintain an adequate cardiac output (230,231). Similarly, controversy exists about management of blood pressure in the perioperative period (232), particularly with regard to systolic pressure (233) and pulse pressure (234). Intraoperative hypotension is considered to be a risk factor for adverse outcomes in patients undergoing many types of surgery. Unique to CABG are unavoidable periods of hypotension associated with surgical manipulation, cannulation for CPB, weaning from CPB, or during suspension and stabilization of the heart with off-pump CABG. Minimization of such periods is desirable but is often difficult to achieve, particularly in patients who are unstable hemodynamically.

2.2. Clinical Subsets

2.2.1. CABG in Patients With Acute MI: Recommendations

CLASS I

1. Emergency CABG is recommended in patients with acute MI in whom 1) primary PCI has failed or cannot be performed, 2) coronary anatomy is suitable for CABG, and 3) persistent ischemia of a significant area of myocardium at rest and/or hemodynamic instability refractory to nonsurgical therapy is present (235–239). *(Level of Evidence: B)*
2. Emergency CABG is recommended in patients undergoing surgical repair of a postinfarction mechanical complication of MI, such as ventricular septal rupture, mitral valve insufficiency because of papillary muscle infarction and/or rupture, or free wall rupture (240–244). *(Level of Evidence: B)*
3. Emergency CABG is recommended in patients with cardiogenic shock and who are suitable for CABG irrespective of the time interval from MI to onset of shock and time from MI to CABG (238,245–247). *(Level of Evidence: B)*
4. Emergency CABG is recommended in patients with life-threatening ventricular arrhythmias (believed to be ischemic in origin) in the presence of left main stenosis greater than or equal to 50% and/or 3-vessel CAD (248). *(Level of Evidence: C)*

CLASS IIa

1. The use of CABG is reasonable as a revascularization strategy in patients with multivessel CAD with recurrent angina or MI within the first 48 hours of STEMI presentation as an alternative to a more delayed strategy (235,237,239,249). *(Level of Evidence: B)*
2. Early revascularization with PCI or CABG is reasonable for selected patients greater than 75 years of age with ST-segment elevation or left bundle branch block who are suitable for revascularization irrespective of the time interval from MI to onset of shock (250–254). *(Level of Evidence: B)*

CLASS III: HARM

1. Emergency CABG should not be performed in patients with persistent angina and a small area of viable myocardium who are stable hemodynamically. *(Level of Evidence: C)*
2. Emergency CABG should not be performed in patients with no-reflow (successful epicardial reperfusion with unsuccessful microvascular reperfusion). *(Level of Evidence: C)*

See Online Data Supplement 5 for additional data on CABG in patients with acute myocardial infarction.

With the widespread use of fibrinolytic therapy or primary PCI in subjects with STEMI, emergency CABG is now reserved for those with 1) left main and/or 3-vessel CAD, 2) ongoing ischemia after successful or failed PCI, 3) coronary anatomy not amenable to PCI, 4) a mechanical complication of STEMI (241,255,256), and 5) cardiogenic shock (defined as hypotension [systolic arterial pressure <90 mm Hg for ≥ 30 minutes or need for supportive measures to maintain a systolic pressure ≥ 90 mm Hg], evidence of end-organ hypoperfusion, cardiac index ≤ 2.2 L/min/m^2, and pulmonary capillary wedge pressure ≥ 15 mm Hg) (245,247). In the SHOCK (Should We Emergently Revascularize Occluded Coronaries for Cardiogenic Shock) trial, 36% of patients randomly assigned to early revascularization therapy underwent emergency CABG (245). Although those who underwent emergency CABG were more likely to be diabetic and to have complex coronary anatomy than were those who had PCI, the survival rates of the 2 groups were similar (247). The outcomes of high-risk STEMI patients with cardiogenic shock undergoing emergency CABG suggest that CABG may be preferred to PCI in this patient population when complete revascularization cannot be accomplished with PCI (236,238,246).

The need for emergency CABG in subjects with STEMI is relatively uncommon, ranging from 3.2% to 10.9% (257,258). Of the 1,572 patients enrolled in the DANAMI-2 (Danish Multicenter Randomized Study on Thrombolytic Therapy Versus Acute Coronary Angioplasty in Acute Myocardial Infarction) study, only 50 (3.2%) underwent CABG within 30 days (30 patients initially treated with PCI and 20 given fibrinolysis), and only 3 patients (0.2%) randomly assigned to receive primary PCI underwent emergency CABG (257). Of the 1,100 patients who underwent coronary angiography in the PAMI-2 (Primary Angioplasty in Myocardial Infarction) trial, CABG was performed before hospital discharge in 120 (258).

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The in-hospital mortality rate is higher in STEMI patients undergoing emergency CABG than in those undergoing it on a less urgent or a purely elective basis (239,257,259–264). In a study of 1,181 patients undergoing CABG, the in-hospital mortality rate increased as the patients' preoperative status worsened, ranging from 1.2% in those with stable angina to 26% in those with cardiogenic shock (265).

Although patients requiring emergency or urgent CABG after STEMI are at higher risk than those undergoing it electively, the optimal timing of CABG after STEMI is controversial. A retrospective study performed before the widespread availability of fibrinolysis and primary PCI reported an overall in-hospital mortality rate of 5.2% in 440 STEMI patients undergoing CABG as primary reperfusion therapy. Those undergoing CABG ≤6 hours after symptom onset had a lower in-hospital and long-term (10 years) mortality rate than those undergoing CABG >6 hours after symptom onset (237). Other studies have provided conflicting results, because of, at least in part, the lack of clear delineation between STEMI and NSTEMI patients in these large database reports (259,265). In an analysis of 9,476 patients hospitalized with an acute coronary syndrome (ACS) who underwent CABG during the index hospitalization, 1,344 (14%) were STEMI patients with shock or intra-aortic balloon placement preoperatively (264). These individuals had a mortality rate of 4% when CABG was performed on the third hospital day, which was lower than the mortality rates reported when CABG was performed earlier or later during the hospitalization (264). In studies in which the data from STEMI patients were analyzed separately with regard to the optimal timing of CABG, however, the results appear to be different. In 1 analysis of 44,365 patients who underwent CABG after MI (22,984 with STEMI; 21,381 with NSTEMI), the in-hospital mortality rate was similar in the 2 groups undergoing CABG <6 hours after diagnosis (12.5% and 11.5%, respectively), but it was higher in STEMI patients than in NSTEMI patients when CABG was performed 6 to 23 hours after diagnosis (13.6% versus 6.2%; p=0.006) (262). The groups had similar in-hospital mortality rates when CABG was performed at all later time points (1 to 7 days, 8 to 14 days, and ≥15 days after the acute event) (262). Similarly, in a study of 138 subjects with STEMI unresponsive to maximal nonsurgical therapy who underwent emergency CABG, the overall mortality rate was 8.7%, but it varied according to the time interval from symptom onset to time of operation. The mortality rate was 10.8% for patients undergoing CABG within 6 hours of the onset of symptoms, 23.8% in those undergoing CABG 7 to 24 hours after symptom onset, 6.7% in patients undergoing CABG from 1 to 3 days, 4.2% in those who underwent surgery from 4 to 7 days, and 2.4% after 8 days (266). In an analysis of data from 150 patients with STEMI who did not qualify for primary PCI and required CABG, the in-hospital mortality rate increased according to the time interval between symptom onset and surgery (239). The mortality rate was 6.1% for subjects who underwent CABG within 6 hours of pain onset, 50% in those who underwent CABG 7 to 23 hours after pain onset, and 7.1% in those who underwent CABG after 15 days (239). Lastly, in another study, the time interval of 6 hours was also found to be important in STEMI patients requiring CABG. The mean time from symptom onset to CABG was significantly shorter in survivors versus nonsurvivors (5.1±2.7 hours versus 11.4±3.2 hours; p<0.0007) (235). In patients with cardiogenic shock, the benefits of early revascularization were apparent across a wide time interval between 1) MI and the onset of shock and 2) MI and CABG. Therefore, although CABG exerts its most profound salutary effect when it is performed as soon as possible after MI and the appearance of shock, the time window in which it is beneficial is quite broad.

Apart from the timing of CABG, the outcomes of STEMI patients undergoing CABG depend on baseline demographic variables. Those with mechanical complications of STEMI (e.g., ventricular septal rupture or mitral regurgitation caused by papillary muscle rupture) have a high operative mortality rate (240–242,244,255,267). In a study of 641 subjects with ACS, 22 with evolving STEMI and 20 with a mechanical complication of STEMI were referred for emergency CABG; the 30-day mortality rate was 0% in those with evolving STEMI and 25% in those with a mechanical complication of STEMI (268). In those with mechanical complications, several variables were predictive of death, including advanced age, female sex, cardiogenic shock, the use of intra-aortic balloon counterpulsation preoperatively, pulmonary disease, renal insufficiency, and magnitude of elevation of the serum troponin concentration (235,239,263,265,266,269,270).

2.2.2. Life-Threatening Ventricular Arrhythmias: Recommendations

CLASS I

1. CABG is recommended in patients with resuscitated sudden cardiac death or sustained ventricular tachycardia thought to be caused by significant CAD (≥50% stenosis of left main coronary artery and/or ≥70% stenosis of 1, 2, or all 3 epicardial coronary arteries) and resultant myocardial ischemia (248,271,272). *(Level of Evidence: B)*

CLASS III: HARM

1. CABG should not be performed in patients with ventricular tachycardia with scar and no evidence of ischemia. *(Level of Evidence: C)*

See Online Data Supplement 6 for additional data on life-threatening ventricular arrhythmias.

Most studies evaluating the benefits of CABG in patients with ventricular arrhythmias have examined survivors of out-of-hospital cardiac arrest as well as patients with inducible ventricular tachycardia or fibrillation during electrophysiological study (272–274). In general, CABG has been more effective in reducing the occurrence of ventricular fibrillation than of ventricular tachycardia, because the mechanism of the latter is usually reentry with scarred

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endocardium rather than ischemia. Observational studies have demonstrated a favorable prognosis of subjects undergoing CABG for ischemic ventricular tachycardia/fibrillation (248).

In survivors of cardiac arrest who have severe but operable CAD, CABG can suppress the appearance of arrhythmias, reduce subsequent episodes of cardiac arrest, and result in a good long-term outcome (271–273). It is particularly effective when an ischemic cause of the arrhythmia can be documented (for instance, when it occurs with exercise) (275). Still, because CABG may not alleviate all the factors that predispose to ventricular arrhythmias, concomitant insertion of an implantable cardioverter-defibrillator is often warranted (276). Similarly, continued inducibility or clinical recurrence of ventricular tachycardia after CABG usually requires an implantable cardioverter-defibrillator implantation.

Patients with depressed LV systolic function, advanced age, female sex, and increased CPB time are at higher risk for life-threatening arrhythmias in the early postoperative period. Given the poor short-term prognosis of those with these arrhythmias, mechanical and ischemic causes should be considered in the postoperative setting (277–279).

2.2.3. Emergency CABG After Failed PCI: Recommendations

CLASS I

1. Emergency CABG is recommended after failed PCI in the presence of ongoing ischemia or threatened occlusion with substantial myocardium at risk (280,281). *(Level of Evidence: B)*
2. Emergency CABG is recommended after failed PCI for hemodynamic compromise in patients without impairment of the coagulation system and without a previous sternotomy (280,282,283). *(Level of Evidence: B)*

CLASS IIa

1. Emergency CABG is reasonable after failed PCI for retrieval of a foreign body (most likely a fractured guidewire or stent) in a crucial anatomic location. *(Level of Evidence: C)*
2. Emergency CABG can be beneficial after failed PCI for hemodynamic compromise in patients with impairment of the coagulation system and without previous sternotomy. *(Level of Evidence: C)*

CLASS IIb

1. Emergency CABG might be considered after failed PCI for hemodynamic compromise in patients with previous sternotomy. *(Level of Evidence: C)*

CLASS III: HARM

1. Emergency CABG should not be performed after failed PCI in the absence of ischemia or threatened occlusion. *(Level of Evidence: C)*
2. Emergency CABG should not be performed after failed PCI if revascularization is impossible because of target anatomy or a no-reflow state. *(Level of Evidence: C)*

See Online Data Supplement 7 for additional data on CABG after failed PCI.

With widespread stent use as well as effective antiplatelet and antithrombotic therapies, emergency CABG after failed PCI is not commonly performed. In a 2009 analysis of data from almost 22,000 patients undergoing PCI at a single center, only 90 (0.4%) required CABG within 24 hours of PCI (281). A similarly low rate (≤0.8%) of emergency CABG after PCI has been reported by others (284–286). The indications for emergency CABG after PCI include 1) acute (or threatened) vessel closure, 2) coronary arterial dissection, 3) coronary arterial perforation (281), and 4) malfunction of PCI equipment (e.g., stent dislodgement, fractured guidewire). Subjects most likely to require emergency CABG after failed PCI are those with evolving STEMI, cardiogenic shock, 3-vessel CAD, or the presence of a type C coronary arterial lesion (defined as >2 cm in length, an excessively tortuous proximal segment, an extremely angulated segment, a total occlusion >3 months in duration, or a degenerated SVG that appears to be friable) (281).

In those in whom emergency CABG for failed PCI is performed, morbidity and mortality rates are increased compared with those undergoing elective CABG (287–289), resulting at least in part from the advanced age of many patients now referred for PCI, some of whom have multiple comorbid conditions and complex coronary anatomy. Several variables have been shown to be associated with increased perioperative morbidity and mortality rates, including 1) depressed LV systolic function (290), 2) recent ACS (290,291), 3) multivessel CAD and complex lesion morphology (291,292), 4) cardiogenic shock (281), 5) advanced patient age (293), 6) absence of angiographic collaterals (293), 7) previous PCI (294), and 8) a prolonged time delay in transfer to the operating room (293). In patients undergoing emergency CABG for failed PCI, an off-pump procedure may be associated with a reduced incidence of renal failure, need for intra-aortic balloon use, and reoperation for bleeding (283,295).

If complete revascularization is achieved with minimal delay in patients undergoing emergency CABG after failed PCI, long-term prognosis is similar to that of subjects undergoing elective CABG (280,282,296). In-hospital morbidity and mortality rates in women (297) and the elderly (298) undergoing emergency CABG for failed PCI are relatively high, but the long-term outcomes in these individuals are comparable to those achieved in men and younger patients.

2.2.4. CABG in Association With Other Cardiac Procedures: Recommendations

CLASS I

1. CABG is recommended in patients undergoing noncoronary cardiac surgery with greater than or equal to 50% luminal diameter narrowing of the left main coronary artery or greater than or equal to 70% luminal diameter narrowing of other major coronary arteries. *(Level of Evidence: C)*

CLASS IIa

1. The use of the LIMA is reasonable to bypass a significantly narrowed LAD artery in patients undergoing noncoronary cardiac surgery. *(Level of Evidence: C)*

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2. CABG of moderately diseased coronary arteries (>50% luminal diameter narrowing) is reasonable in patients undergoing noncoronary cardiac surgery. (*Level of Evidence: C*)

3. CAD Revascularization

Recommendations and text in this section are the result of extensive collaborative discussions between the PCI and CABG writing committees, as well as key members of the Stable Ischemic Heart Disease (SIHD) and UA/NSTEMI writing committees. Certain issues, such as older versus more contemporary studies, primary analyses versus subgroup analyses, and prospective versus post hoc analyses, have been carefully weighed in designating COR and LOE; they are addressed in the appropriate corresponding text. The goals of revascularization for patients with CAD are to 1) to improve survival and 2) to relieve symptoms.

Revascularization recommendations in this section are predominantly based on studies of patients with symptomatic SIHD and should be interpreted in this context. As discussed later in this section, recommendations on the type of revascularization are, in general, applicable to patients with UA/NSTEMI. In some cases (e.g., unprotected left main CAD), specific recommendations are made for patients with UA/NSTEMI or STEMI.

Historically, most studies of revascularization have been based on and reported according to angiographic criteria. Most studies have defined a "significant" stenosis as ≥70% diameter narrowing; therefore, for revascularization decisions and recommendations in this section, a "significant" stenosis has been defined as ≥70% diameter narrowing (≥50% for left main CAD). Physiological criteria, such as an assessment of fractional flow reserve, has been used in deciding when revascularization is indicated. Thus, for recommendations on revascularization in this section, coronary stenoses with fractional flow reserve ≤0.80 can also be considered "significant" (299,300).

As noted, the revascularization recommendations have been formulated to address issues related to 1) improved survival and/or 2) improved symptoms. When one method of revascularization is preferred over the other for improved survival, this consideration, in general, takes precedence over improved symptoms. When discussing options for revascularization with the patient, he or she should understand when the procedure is being performed in an attempt to improve symptoms, survival, or both.

Although some results from the SYNTAX (Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery) study are best characterized as subgroup analyses and "hypothesis generating," SYNTAX nonetheless represents the latest and most comprehensive comparison of contemporary PCI and CABG (301,302). Therefore, the results of SYNTAX have been considered appropriately when formulating our revascularization recommendations. Although the limitations of using the SYNTAX score for certain revascularization recommendations are recognized, the SYNTAX score is a reasonable surrogate for the extent of CAD and its complexity and serves as important information that should be considered when making revascularization decisions. Recommendations that refer to SYNTAX scores use them as surrogates for the extent and complexity of CAD.

Revascularization recommendations to improve survival and symptoms are given in the following text and summarized in Tables 2 and 3. References to studies comparing revascularization with medical therapy are presented when available for each anatomic subgroup.

See Online Data Supplements 8 and 9 for additional data regarding the survival and symptomatic benefits with CABG or PCI for different anatomic subsets.

3.1. Heart Team Approach to Revascularization Decisions: Recommendations

CLASS I

1. A Heart Team approach to revascularization is recommended in patients with unprotected left main or complex CAD (302–304). (*Level of Evidence: C*)

CLASS IIa

1. Calculation of the STS and SYNTAX scores is reasonable in patients with unprotected left main and complex CAD (301,302,305–310). (*Level of Evidence: B*)

One protocol used in RCTs (302–304,311) often involves a multidisciplinary approach referred to as the Heart Team. Composed of an interventional cardiologist and a cardiac surgeon, the Heart Team 1) reviews the patient's medical condition and coronary anatomy, 2) determines that PCI and/or CABG are technically feasible and reasonable, and 3) discusses revascularization options with the patient before a treatment strategy is selected. Support for using a Heart Team approach comes from reports that patients with complex CAD referred specifically for PCI or CABG in concurrent trial registries have lower mortality rates than those randomly assigned to PCI or CABG in controlled trials (303,304).

The SIHD, PCI, and CABG guideline writing committees endorse a Heart Team approach in patients with unprotected left main CAD and/or complex CAD in whom the optimal revascularization strategy is not straightforward. A collaborative assessment of revascularization options, or the decision to treat with GDMT without revascularization, involving an interventional cardiologist, a cardiac surgeon, and (often) the patient's general cardiologist, followed by discussion with the patient about treatment options, is optimal. Particularly in patients with SIHD and unprotected left main and/or complex CAD for whom a revascularization strategy is not straightforward, an approach has been endorsed that involves terminating the procedure after diagnostic coronary angiography is completed; this allows a thorough discussion and affords both the interventional cardiologist and cardiac surgeon the opportunity to discuss

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Table 2. Revascularization to Improve Survival Compared With Medical Therapy

Anatomic Setting	COR	LOE	References
UPLM or complex CAD			
CABG and PCI	I—Heart Team approach recommended	C	(302–304)
CABG and PCI	IIa—Calculation of the STS and SYNTAX scores	B	(301,302,305–310)
UPLM*			
CABG	I	B	(312–318)
PCI	IIa—For SIHD when both of the following are present: • Anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX score of ≤22, ostial or trunk left main CAD) • Clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%)	B	(301,305,307,311,319–336)
	IIa—For UA/NSTEMI if not a CABG candidate	B	(301,324–327,332,333, 335–337)
	IIa—For STEMI when distal coronary flow is TIMI flow grade <3 and PCI can be performed more rapidly and safely than CABG	C	(321,338,339)
	IIb—For SIHD when *both* of the following are present: • Anatomic conditions associated with a low to intermediate risk of PCI procedural complications and intermediate to high likelihood of good long-term outcome (e.g., low–intermediate SYNTAX score of <33, bifurcation left main CAD) • Clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate–severe COPD, disability from prior stroke, or prior cardiac surgery; STS-predicted risk of operative mortality >2%)	B	(301,305,307,311, 319–336,340)
	III: Harm—For SIHD in patients (versus performing CABG) with unfavorable anatomy for PCI and who are good candidates for CABG	B	(301,305,307,312–320)
3-vessel disease with or without proximal LAD artery disease*			
CABG	I	B	(314,318,341–344)
	IIa—It is reasonable to choose CABG over PCI in patients with complex 3-vessel CAD (e.g., SYNTAX >22) who are good candidates for CABG	B	(320,334,343,359–360)
PCI	IIb—Of uncertain benefit	B	(314,341,343,370).
2-vessel disease with proximal LAD artery disease*			
CABG	I	B	(314,318,341–344)
PCI	IIb—Of uncertain benefit	B	(314,341,343,370)
2-vessel disease without proximal LAD artery disease*			
CABG	IIa—With extensive ischemia	B	(348–351)
	IIb—Of uncertain benefit without extensive ischemia	C	(343)
PCI	IIb—Of uncertain benefit	B	(314,341,343,370)
1-vessel proximal LAD artery disease			
CABG	IIa—With LIMA for long-term benefit	B	(87,88,318,343)
PCI	IIb—Of uncertain benefit	B	(314,341,343,370)
1-vessel disease without proximal LAD artery involvement			
CABG	III: Harm	B	(318,341,348,349, 382–386)
PCI	III: Harm	B	(318,341,348,349, 382–386)
LV dysfunction			
CABG	IIa—EF 35% to 50%	B	(318,352–356)
CABG	IIb—EF <35% without significant left main CAD	B	(318,352–356,371,372)
PCI	Insufficient data		N/A
Survivors of sudden cardiac death with presumed ischemia-mediated VT			
CABG	I	B	(271,345,347)
PCI	I	C	(345)
No anatomic or physiological criteria for revascularization			
CABG	III: Harm	B	(318,341,348,349,382–386)
PCI	III: Harm	B	(318,341,348,349,382–386)

In patients with multivessel disease who also have diabetes, it is reasonable to choose CABG (with LIMA) over PCI (350,362–369) *(Class IIa/LOE: B).

CABG indicates coronary artery bypass graft; CAD, coronary artery disease; COPD, chronic obstructive pulmonary disease; COR, class of recommendation; EF, ejection fraction; LAD, left anterior descending; LIMA, left internal mammary artery; LOE, level of evidence; LV, left ventricular; N/A, not applicable; PCI, percutaneous coronary intervention; SIHD, stable ischemic heart disease; STEMI, ST-elevation myocardial infarction; STS, Society of Thoracic Surgeons; SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery; TIMI, Thrombolysis In Myocardial Infarction; UA/NSTEMI, unstable angina/non–ST-elevation myocardial infarction; UPLM, unprotected left main disease; and VT, ventricular tachycardia.

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Table 3. Revascularization to Improve Symptoms With Significant Anatomic (≥50% Left Main or ≥70% Non–Left Main CAD) or Physiological (FFR≤0.80) Coronary Artery Stenoses

Clinical Setting	COR	LOE	References
≥1 significant stenoses amenable to revascularization and unacceptable angina despite GDMT	I—CABG I—PCI	A	(370,387–396)
≥1 significant stenoses and unacceptable angina in whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences	IIa—CABG IIa—PCI	C	N/A
Previous CABG with ≥1 significant stenoses associated with ischemia and unacceptable angina despite GDMT	IIa—PCI	C	(374,377,380)
	IIb—CABG	C	(381)
Complex 3-vessel CAD (e.g., SYNTAX score >22) with or without involvement of the proximal LAD artery and a good candidate for CABG	IIa—CABG preferred over PCI	B	(320,343,359–361)
Viable ischemic myocardium that is perfused by coronary arteries that are not amenable to grafting	IIb—TMR as an adjunct to CABG	B	(397–401)
No anatomic or physiologic criteria for revascularization	III: Harm—CABG III: Harm—PCI	C	N/A

CABG indicates coronary artery bypass graft; CAD, coronary artery disease; COR, class of recommendation; FFR, fractional flow reserve; GDMT, guideline-directed medical therapy; LOE, level of evidence; N/A, not applicable; PCI, percutaneous coronary intervention; SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery; and TMR, transmyocardial laser revascularization.

revascularization options with the patient. Because the STS score and the SYNTAX score have been shown to predict adverse outcomes in patients undergoing CABG and PCI, respectively, calculation of these scores is often useful in making revascularization decisions (301,302,305–310).

3.2. Revascularization to Improve Survival: Recommendations

Left Main CAD Revascularization

CLASS I

1. CABG to improve survival is recommended for patients with significant (≥50% diameter stenosis) left main coronary artery stenosis (312–318). *(Level of Evidence: B)*

CLASS IIa

1. PCI to improve survival is reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX score [≤22], ostial or trunk left main CAD); and 2) clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%) (301,305,307,311,319–336). *(Level of Evidence: B)*
2. PCI to improve survival is reasonable in patients with UA/NSTEMI when an unprotected left main coronary artery is the culprit lesion and the patient is not a candidate for CABG (301,324–327,332, 333,335–337). *(Level of Evidence: B)*
3. PCI to improve survival is reasonable in patients with acute STEMI when an unprotected left main coronary artery is the culprit lesion, distal coronary flow is less than Thrombolysis In Myocardial Infarction grade 3, and PCI can be performed more rapidly and safely than CABG (321,338,339). *(Level of Evidence: C)*

CLASS IIb

1. PCI to improve survival may be reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low–intermediate SYNTAX score of <33, bifurcation left main CAD); and 2) clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate–severe chronic obstructive pulmonary disease, disability from previous stroke, or previous cardiac surgery; STS-predicted risk of operative mortality >2%) (301,305,307,311,319–336,340). *(Level of Evidence: B)*

CLASS III: HARM

1. PCI to improve survival should not be performed in stable patients with significant (≥50% diameter stenosis) unprotected left main CAD who have unfavorable anatomy for PCI and who are good candidates for CABG (301,305,307,312–320). *(Level of Evidence: B)*

Non–Left Main CAD Revascularization

CLASS I

1. CABG to improve survival is beneficial in patients with significant (≥70% diameter) stenoses in 3 major coronary arteries (with or without involvement of the proximal LAD artery) or in the proximal LAD plus 1 other major coronary artery (314,318,341–344). *(Level of Evidence: B)*
2. CABG or PCI to improve survival is beneficial in survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia caused by significant (≥70% diameter) stenosis in a major coronary artery. *(CABG Level of Evidence: B [271,345,347]; PCI Level of Evidence: C [345])*

CLASS IIa

1. CABG to improve survival is reasonable in patients with significant (≥70% diameter) stenoses in 2 major coronary arteries with severe or extensive myocardial ischemia (e.g., high-risk criteria on stress testing, abnormal intracoronary hemodynamic evaluation, or >20% perfusion defect by myocardial perfusion stress imaging) or target vessels supplying a large area of viable myocardium (348–351). *(Level of Evidence: B)*
2. CABG to improve survival is reasonable in patients with mild-moderate LV systolic dysfunction (EF 35% to 50%) and significant (≥70% diameter stenosis) multivessel CAD or proximal LAD coronary artery stenosis, when viable myocardium is present in the region of intended revascularization (318,352–356). *(Level of Evidence: B)*

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3. CABG with a LIMA graft to improve survival is reasonable in patients with significant (≥70% diameter) stenosis in the proximal LAD artery and evidence of extensive ischemia (87,88,318,343). *(Level of Evidence: B)*
4. It is reasonable to choose CABG over PCI to improve survival in patients with complex 3-vessel CAD (e.g., SYNTAX score >22), with or without involvement of the proximal LAD artery, who are good candidates for CABG (320,334,343,359–360). *(Level of Evidence: B)*
5. CABG is probably recommended in preference to PCI to improve survival in patients with multivessel CAD and diabetes mellitus, particularly if a LIMA graft can be anastomosed to the LAD artery (350,362–369). *(Level of Evidence: B)*

CLASS IIb

1. The usefulness of CABG to improve survival is uncertain in patients with significant (≥70%) stenoses in 2 major coronary arteries not involving the proximal LAD artery and without extensive ischemia (343). *(Level of Evidence: C)*
2. The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease (314,341,343,370). *(Level of Evidence: B)*
3. CABG might be considered with the primary or sole intent of improving survival in patients with SIHD with severe LV systolic dysfunction (EF <35%) whether or not viable myocardium is present (318,352–356,371,372). *(Level of Evidence: B)*
4. The usefulness of CABG or PCI to improve survival is uncertain in patients with previous CABG and extensive anterior wall ischemia on noninvasive testing (373–381). *(Level of Evidence: B)*

CLASS III: HARM

1. CABG or PCI should not be performed with the primary or sole intent to improve survival in patients with SIHD with 1 or more coronary stenoses that are not anatomically or functionally significant (e.g., <70% diameter non–left main coronary artery stenosis, fractional flow reserve >0.80, no or only mild ischemia on noninvasive testing), involve only the left circumflex or right coronary artery, or subtend only a small area of viable myocardium (318,341,348,349, 382–386). *(Level of Evidence: B)*

3.3. Revascularization to Improve Symptoms: Recommendations

CLASS I

1. CABG or PCI to improve symptoms is beneficial in patients with 1 or more significant (≥70% diameter) coronary artery stenoses amenable to revascularization and unacceptable angina despite GDMT (370,387–396). *(Level of Evidence: A)*

CLASS IIa

1. CABG or PCI to improve symptoms is reasonable in patients with 1 or more significant (≥70% diameter) coronary artery stenoses and unacceptable angina for whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences. *(Level of Evidence: C)*
2. PCI to improve symptoms is reasonable in patients with previous CABG, 1 or more significant (≥70% diameter) coronary artery stenoses associated with ischemia, and unacceptable angina despite GDMT (374,377,380). *(Level of Evidence: C)*
3. It is reasonable to choose CABG over PCI to improve symptoms in patients with complex 3-vessel CAD (e.g., SYNTAX score >22), with or without involvement of the proximal LAD artery, who are good candidates for CABG (320,334,343,359–360). *(Level of Evidence: B)*

CLASS IIb

1. CABG to improve symptoms might be reasonable for patients with previous CABG, 1 or more significant (≥70% diameter) coronary artery stenoses not amenable to PCI, and unacceptable angina despite GDMT (381). *(Level of Evidence: C)*
2. Transmyocardial laser revascularization (TMR) performed as an adjunct to CABG to improve symptoms may be reasonable in patients with viable ischemic myocardium that is perfused by arteries that are not amenable to grafting (397–401). *(Level of Evidence: B)*

CLASS III: HARM

1. CABG or PCI to improve symptoms should not be performed in patients who do not meet anatomic (≥50% left main or ≥70% non–left main stenosis) or physiological (e.g., abnormal fractional flow reserve) criteria for revascularization. *(Level of Evidence: C)*

3.4. CABG Versus Contemporaneous Medical Therapy

In the 1970s and 1980s, 3 RCTs established the survival benefit of CABG compared with contemporaneous (although minimal by current standards) medical therapy without revascularization in certain subjects with stable angina: the Veterans Affairs Cooperative Study (402), European Coronary Surgery Study (344), and CASS (Coronary Artery Surgery Study) (403). Subsequently, a 1994 meta-analysis of 7 studies that randomized a total of 2,649 patients to medical therapy for CABG (318) showed that CABG offered a survival advantage over medical therapy for patients with left main or 3-vessel CAD. The studies also established that CABG is more effective than medical therapy at relieving anginal symptoms. These studies have been replicated only once during the past decade. In MASS II (Medicine, Angioplasty, or Surgery Study II), patients with multivessel CAD who were treated with CABG were less likely than those treated with medical therapy to have a subsequent MI, need additional revascularization, or experience cardiac death in the 10 years after randomization (392).

Surgical techniques and medical therapy have improved substantially during the intervening years. As a result, if CABG were to be compared with GDMT in RCTs today, the relative benefits for survival and angina relief observed several decades ago might no longer be observed. Conversely, the concurrent administration of GDMT may substantially improve long-term outcomes in patients treated with CABG in comparison with those receiving medical therapy alone. In the BARI 2D (Bypass Angioplasty Revascularization Investigation 2 Diabetes) trial of patients with diabetes mellitus, no significant difference in risk of mortality in the cohort of patients randomized to GDMT plus CABG or GDMT alone was observed, although the study was not powered for this endpoint, excluded patients with significant left main CAD, and included only a small percentage of patients with proximal LAD artery disease or LV ejection fraction (LVEF) <0.50 (404). The PCI and CABG guideline writing committees endorse the performance of the ISCHEMIA (International Study of Comparative Health Effectiveness with Medical and Invasive Approaches) trial,

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which will provide contemporary data on the optimal management strategy (medical therapy or revascularization with CABG or PCI) of patients with SIHD, including multivessel CAD, and moderate to severe ischemia.

3.5. PCI Versus Medical Therapy

Although contemporary interventional treatments have lowered the risk of restenosis compared with earlier techniques, meta-analyses have failed to show that the introduction of bare-metal stents (BMS) confers a survival advantage over balloon angioplasty (405–407) or that the use of drug-eluting stents (DES) confers a survival advantage over BMS (407,408).

No study to date has demonstrated that PCI in patients with SIHD improves survival rates (314,341,343,370,404,407,409–412). Neither COURAGE (Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation) (370) nor BARI 2D (404), which treated all patients with contemporary optimal medical therapy, demonstrated any survival advantage with PCI, although these trials were not specifically powered for this endpoint. Although 1 large analysis evaluating 17 RCTs of PCI versus medical therapy (including 5 trials of subjects with ACS) found a 20% reduction in death with PCI compared with medical therapy (411), 2 other large analyses did not (407,410). An evaluation of 13 studies reporting the data from 5,442 patients with nonacute CAD showed no advantage of PCI over medical therapy for the individual endpoints of all-cause death, cardiac death or MI, or nonfatal MI (412). Evaluation of 61 trials of PCI conducted over several decades shows that despite improvements in PCI technology and pharmacotherapy, PCI has not been demonstrated to reduce the risk of death or MI in patients without recent ACS (407).

The findings from individual studies and systematic reviews of PCI versus medical therapy can be summarized as follows:

- PCI reduces the incidence of angina (370,387,392,395,396,413).
- PCI has not been demonstrated to improve survival in stable patients (407,409,410).
- PCI may increase the short-term risk of MI (370,409,413,414).
- PCI does not lower the long-term risk of MI (370,404,407,409,410,414).

3.6. CABG Versus PCI

The results of 26 RCTs comparing CABG and PCI have been published: Of these, 9 compared CABG with balloon angioplasty (363,393,415–429), 14 compared CABG with BMS implantation (376,430–447), and 3 compared CABG with DES implantation (302,448,449).

3.6.1. CABG Versus Balloon Angioplasty or BMS

A systematic review of the 22 RCTs comparing CABG with balloon angioplasty or BMS implantation concluded the following (450):

1. Survival was similar for CABG and PCI (with balloon angioplasty or BMS) at 1 year and 5 years. Survival was similar for CABG and PCI in subjects with 1-vessel CAD (including those with disease of the proximal portion of the LAD artery) or multivessel CAD.
2. Incidence of MI was similar at 5 years after randomization.
3. Procedural stroke occurred more commonly with CABG than with PCI (1.2% versus 0.6%).
4. Relief of angina was accomplished more effectively with CABG than with PCI 1 year after randomization and 5 years after randomization.
5. During the first year after randomization, repeat coronary revascularization was performed less often after CABG than after PCI (3.8% versus 26.5%). This was also demonstrated after 5 years of follow-up (9.8% versus 46.1%). This difference was more pronounced with balloon angioplasty than with BMS.

A collaborative analysis of data from 10 RCTs comparing CABG with balloon angioplasty (6 trials) or with BMS implantation (4 trials) (451) permitted subgroup analyses of the data from the 7,812 patients. No difference was noted with regard to mortality rate 5.9 years after randomization or the composite endpoint of death or MI. Repeat revascularization and angina were noted more frequently in those treated with balloon angioplasty or BMS implantation (451). The major new observation of this analysis was that CABG was associated with better outcomes in patients with diabetes mellitus and in those >65 years old. Of interest, the relative outcomes of CABG and PCI were not influenced by other patient characteristics, including the number of diseased coronary arteries.

The aforementioned meta-analysis and systematic review (450,451) comparing CABG and balloon angioplasty or BMS implantation were limited in several ways.

1. Many trials did not report outcomes for other important patient subsets. For example, the available data are insufficient to determine if race, obesity, renal dysfunction, peripheral artery disease (PAD), or previous coronary revascularization affected the comparative outcomes of CABG and PCI.
2. Most of the patients enrolled in these trials were male, and most had 1- or 2-vessel CAD and normal LV systolic function (EF >50%)—subjects known to be unlikely to derive a survival benefit and less likely to experience complications after CABG (318).
3. The patients enrolled in these trials represented only a small fraction (generally <5% to 10%) of those who were screened. For example, most screened patients with

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1-vessel CAD and many with 3-vessel CAD were not considered for randomization.

See Online Data Supplements 10 and 11 for additional data comparing CABG with PCI.

3.6.2. CABG Versus DES

Although the results of 9 observational studies comparing CABG and DES implantation have been published (320,452–459), most of them had short (12 to 24 months) follow-up periods. In a meta-analysis of 24,268 patients with multivessel CAD treated with CABG or DES (460), the incidences of death and MI were similar for the 2 procedures, but the frequency with which repeat revascularization was performed was roughly 4 times higher after DES implantation. Only 1 large RCT comparing CABG and DES implantation has been published. The SYNTAX trial randomly assigned 1,800 patients (of a total of 4,337 who were screened) to receive DES or CABG (302,334). Major adverse cardiac events (MACE), a composite of death, stroke, MI, or repeat revascularization during the 3 years after randomization, occurred in 20.2% of CABG patients and 28.0% of those undergoing DES implantation ($p<0.001$). The rates of death and stroke were similar; however, MI (3.6% for CABG; 7.1% for DES) and repeat revascularization (10.7% for CABG; 19.7% for DES) were more likely to occur with DES implantation (334).

In SYNTAX, the extent of CAD was assessed using the SYNTAX score, which is based on the location, severity, and extent of coronary stenoses, with a low score indicating less complicated anatomic CAD. In post hoc analyses, a low score was defined as ≤22; intermediate 23 to 32; and high, ≥33. The occurrence of MACE correlated with the SYNTAX score for DES patients but not for those undergoing CABG. At 12-month follow-up, the primary endpoint was similar for CABG and DES in those with a low SYNTAX score. In contrast, MACE occurred more often after DES implantation than after CABG in those with an intermediate or high SYNTAX score (302). At 3 years of follow-up, the mortality rate was greater in subjects with 3-vessel CAD treated with PCI than in those treated with CABG (6.2% versus 2.9%). The differences in MACE between those treated with PCI or CABG increased with an increasing SYNTAX score (Figure 1) (334).

Although the utility of using a SYNTAX score in everyday clinical practice remains uncertain, it seems reasonable to conclude from SYNTAX and other data that outcomes of patients undergoing PCI or CABG in those with relatively uncomplicated and lesser degrees of CAD are comparable, whereas in those with complex and diffuse CAD, CABG appears to be preferable (334).

See Online Data Supplements 12 and 13 for additional data comparing CABG with DES.

3.7. Left Main CAD

3.7.1. CABG or PCI Versus Medical Therapy for Left Main CAD

CABG confers a survival benefit over medical therapy in patients with left main CAD. Subgroup analyses from RCTs performed 3 decades ago included 91 patients with left main CAD in the Veterans Administration Cooperative Study (316). A meta-analysis of these trials demonstrated a 66% RR reduction in mortality with CABG, with the benefit extending to 10 years (318). The CASS Registry (312) contained data from 1,484 patients with ≥50% left main CAD initially treated surgically or nonsurgically. Median survival duration was 13.3 years in the surgical group and 6.6 years in the medical group. The survival benefit of CABG over medical therapy appeared to extend to 53 asymptomatic patients with left main CAD in the CASS Registry (317). Other therapies that subsequently have been shown to be associated with improved long-term

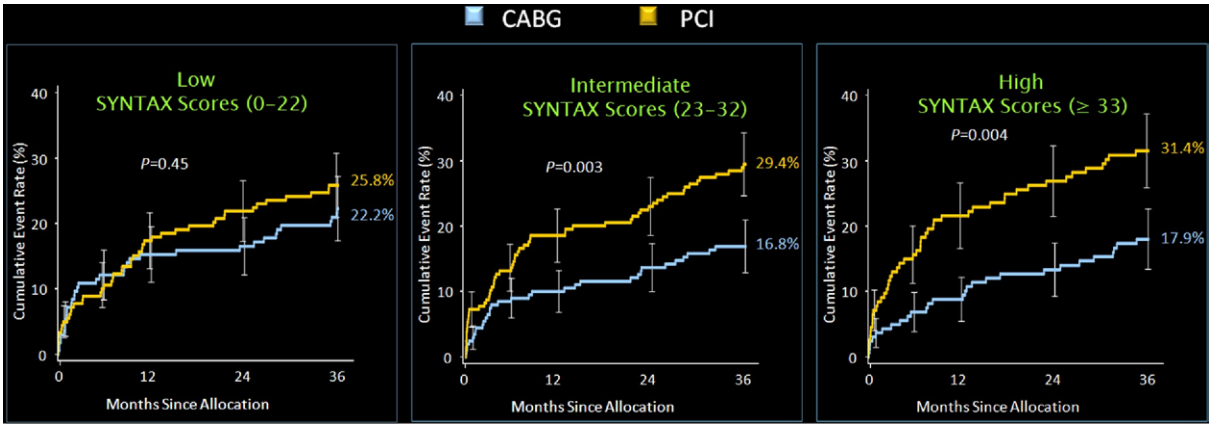

Figure 1. Cumulative Incidence of MACE in Patients With 3-Vessel CAD Based on SYNTAX Score at 3-Year Follow-Up in the SYNTAX Trial Treated With Either CABG or PCI

CABG indicates coronary artery bypass graft; CAD, coronary artery disease; MACE, major adverse cardiovascular event; PCI, percutaneous coronary intervention; and SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery. Adapted with permission from Kappetein (334).

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outcome, such as the use of aspirin, statins, and IMA grafting, were not widely used in that era.

RCTs and subgroup analyses that compare PCI with medical therapy in patients with "unprotected" left main CAD do not exist.

3.7.2. Studies Comparing PCI Versus CABG for Left Main CAD

Of all subjects undergoing coronary angiography, approximately 4% are found to have left main CAD (463), >80% of whom have significant (≥70% diameter) stenoses in other epicardial coronary arteries.

Published cohort studies have found that major clinical outcomes are similar with PCI or CABG 1 year after revascularization and that mortality rates are similar at 1, 2, and 5 years of follow-up; however, the risk of needing target-vessel revascularization is significantly higher with stenting than with CABG.

In the SYNTAX trial, 45% of screened patients with unprotected left main CAD had complex diseases that prevented randomization; 89% of these underwent CABG (301,302). In addition, 705 of the 1,800 patients who were randomized had revascularization for unprotected left main CAD. The majority of patients with left main CAD and a low SYNTAX score had isolated left main CAD or left main CAD plus 1-vessel CAD; the majority of those with an intermediate score had left main CAD plus 2-vessel CAD; and most of those with a high SYNTAX score had left main CAD plus 3-vessel CAD. At 1 year, rates of all-cause death and MACE were similar for the 2 groups (301). Repeat revascularization rates were higher in the PCI group than the CABG group (11.8% versus 6.5%), but stroke occurred more often in the CABG group (2.7% versus 0.3%). At 3 years of follow-up, the incidence of death in those undergoing left main CAD revascularization with low or intermediate SYNTAX scores (≤32) was 3.7% after PCI and 9.1% after CABG (p=0.03), whereas in those with a high SYNTAX score (≥33) the incidence of death after 3 years was 13.4% after PCI and 7.6% after CABG (p=0.10) (334). Because the primary endpoint of SYNTAX was not met (i.e., noninferiority comparison of CABG and PCI), these subgroup analyses need to be considered in that context.

In the LE MANS (Study of Unprotected Left Main Stenting Versus Bypass Surgery) trial (311), 105 patients with left main CAD were randomized to receive PCI or CABG. Although a low proportion of patients treated with PCI received DES (35%) and a low proportion of patients treated with CABG received IMA grafts (72%), the outcomes at 30 days and 1 year were similar between the groups. In the PRECOMBAT (Premier of Randomized Comparison of Bypass Surgery versus Angioplasty Using Sirolimus-Eluting Stent in Patients with Left Main Coronary Artery Disease) trial of 600 patients with left main disease, the composite endpoint of death, MI, or stroke at 2 years occurred in 4.4% of patients treated with PCI and 4.7% of patients treated with CABG, but ischemia-driven target-vessel revascularization was more often required in the patients treated with PCI (9.0% versus 4.2%) (340).

The results from these 3 RCTs suggest (but do not definitively prove) that major clinical outcomes in *selected* patients with left main CAD are similar with CABG and PCI at 1- to 2-year follow-up, but repeat revascularization rates are higher after PCI than after CABG. RCTs with extended follow-up of ≥5 years are required to provide definitive conclusions about the optimal treatment of left main CAD. In a meta-analysis of 8 cohort studies and 2 RCTs (329), death, MI, and stroke occurred with similar frequency in the PCI- and CABG-treated patients at 1, 2, and 3 years of follow-up. Target-vessel revascularization was performed more often in the PCI group at 1 year (OR: 4.36), 2 years (OR: 4.20), and 3 years (OR: 3.30).

See Online Data Supplements 14 to 19 for additional data comparing PCI with CABG for left main CAD.

3.7.3. Revascularization Considerations for Left Main CAD

Although CABG has been considered the "gold standard" for unprotected left main CAD revascularization, more recently PCI has emerged as a possible alternative mode of revascularization in carefully selected patients. Lesion location is an important determinant when considering PCI for unprotected left main CAD. Stenting of the left main ostium or trunk is more straightforward than treating distal bifurcation or trifurcation stenoses, which generally requires a greater degree of operator experience and expertise (464). In addition, PCI of bifurcation disease is associated with higher restenosis rates than when disease is confined to the ostium or trunk (327,465). Although lesion location influences technical success and long-term outcomes after PCI, location exerts a negligible influence on the success of CABG. In subgroup analyses, patients with left main CAD and a SYNTAX score ≥33 with more complex or extensive CAD had a higher mortality rate with PCI than with CABG (334). Physicians can estimate operative risk for all CABG candidates by using a standard instrument, such as the risk calculator from the STS database. The above considerations are important factors when choosing among revascularization strategies for unprotected left main CAD and have been factored into revascularization recommendations. Use of a Heart Team approach has been recommended in cases in which the choice of revascularization is not straightforward. As discussed in Section 3.9.7, the ability of the patient to tolerate and comply with dual antiplatelet therapy (DAPT) is also an important consideration in revascularization decisions.

The 2005 PCI guidelines (466) recommended routine angiographic follow-up 2 to 6 months after stenting for uprotected left main CAD. However, because angiography has limited ability to predict stent thrombosis and the

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results of SYNTAX suggest good intermediate-term results for PCI in subjects with left main CAD, this recommendation was removed in the 2009 STEMI/PCI focused update (467).

Experts have recommended immediate PCI for unprotected left main CAD in the setting of STEMI (339). The impetus for such a strategy is greatest when the left main CAD is the site of the culprit lesion, antegrade coronary flow is diminished [e.g., Thrombolysis In Myocardial Infarction flow grade 0, 1, or 2], the patient is hemodynamically unstable, and it is believed that PCI can be performed more quickly than CABG. When possible, the interventional cardiologist and cardiac surgeon should decide together on the optimal form of revascularization for these subjects, although it is recognized that these patients are usually critically ill and therefore not amenable to a prolonged deliberation or discussion of treatment options.

3.8. Proximal LAD Artery Disease

A cohort study (341) and a meta-analysis (318) from the 1990s suggested that CABG confers a survival advantage over contemporaneous medical therapy for patients with disease in the proximal segment of the LAD artery. Cohort studies and RCTs (318,420,432,433,435,448,468–470) as well as collaborative- and meta-analyses (451,471–473) showed that PCI and CABG result in similar survival rates in these patients.

See Online Data Supplement 20 for additional data regarding proximal LAD artery revascularization.

3.9. Clinical Factors That May Influence the Choice of Revascularization

3.9.1. Diabetes Mellitus

An analysis performed in 2009 of data on 7,812 patients (1,233 with diabetes) in 10 RCTs demonstrated a worse long-term survival rate in patients with diabetes mellitus after balloon angioplasty or BMS implantation than after CABG (451). The BARI 2D trial (404) randomly assigned 2,368 patients with type 2 diabetes and CAD to undergo intensive medical therapy or prompt revascularization with PCI or CABG, according to whichever was thought to be more appropriate. By study design, those with less extensive CAD more often received PCI, whereas those with more extensive CAD were more likely to be treated with CABG. The study was not designed to compare PCI with CABG. At 5-year follow-up, no difference in rates of survival or MACE between the medical therapy group and those treated with revascularization was noted. In the PCI stratum, no significant difference in MACE between medical therapy and revascularization was demonstrated (DES in 35%; BMS in 56%); in the CABG stratum, MACE occurred less often in the revascularization group. One-year follow-up data from the SYNTAX study demonstrated a higher rate of repeat revascularization in patients with diabetes mellitus treated with PCI than with CABG, driven by a tendency for higher repeat revascularization rates in those with higher SYNTAX scores undergoing PCI (364). In summary, in subjects requiring revascularization for multivessel CAD, current evidence supports diabetes mellitus as an important factor when deciding on a revascularization strategy, particularly when complex or extensive CAD is present (Figure 2).

See Online Data Supplements 21 and 22 for additional data regarding diabetes mellitus.

3.9.2. Chronic Kidney Disease

Cardiovascular morbidity and mortality rates are markedly increased in patients with chronic kidney disease (CKD) when compared with age-matched controls without CKD. The mortality rate for patients on hemodialysis is >20% per year, and approximately 50% of deaths among these patients are due to a cardiovascular cause (476,477).

To date, randomized comparisons of coronary revascularization (with CABG or PCI) and medical therapy in patients with CKD have not been reported. Some, but not all, observational studies or subgroup analyses have demonstrated an improved survival rate with revascularization compared with medical therapy in patients with CKD and multivessel CAD (478–480), despite the fact that the incidence of periprocedural complications (e.g., death, MI, stroke, infection, renal failure) is increased in patients with CKD compared with those without renal dysfunction. Some studies have shown that CABG is associated with a greater survival benefit than PCI among patients with severe renal dysfunction (479–485).

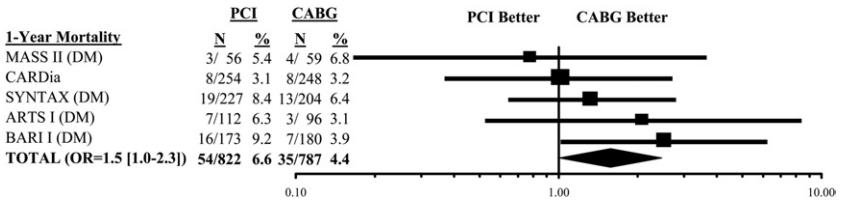

Figure 2. 1-Year Mortality After Revascularization for Multivessel Disease and Diabetes Mellitus

An OR of >1 suggests an advantage of CABG over PCI. ARTS I indicates Arterial Revascularization Therapy Study I (474); BARI I, Bypass Angioplasty Revascularization Investigation I (362); CARDia, Coronary Artery Revascularization in Diabetes (475); CI, confidence interval; DM, diabetes mellitus; MASS II, Medicine, Angioplasty, or Surgery Study II (366); OR, odds ratio; SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery; and W, weighted (364).

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3.9.3. Completeness of Revascularization

Most patients undergoing CABG receive complete or nearly complete revascularization, which seems to influence long-term prognosis positively (486). In contrast, complete revascularization is accomplished less often in subjects receiving PCI (e.g., in <70% of patients), but the extent to which the absence of complete initial revascularization influences outcome is less clear. Rates of late survival and survival free of MI appear to be similar in patients with and without complete revascularization after PCI. Nevertheless, the need for subsequent CABG is usually higher in those whose initial revascularization procedure was incomplete (compared with those with complete revascularization) after PCI (487–489).

3.9.4. LV Systolic Dysfunction

Several older studies and a meta-analysis of the data from these studies reported that patients with LV systolic dysfunction (predominantly mild to moderate in severity) had better survival with CABG than with medical therapy alone (318,352–356). For patients with more severe LV systolic dysfunction, however, the evidence that CABG results in better survival compared with medical therapy is lacking. In the STICH (Surgical Treatment for Ischemic Heart Failure) trial of subjects with LVEF <35% with or without viability testing, CABG and GDMT resulted in similar rates of survival (death from any cause, the study's primary outcome) after 5 years of follow-up. For a number of secondary outcomes at this time point, including 1) death from any cause or hospitalization for heart failure, 2) death from any cause or hospitalization for cardiovascular causes, 3) death from any cause or hospitalization for any cause, or 4) death from any cause or revascularization with PCI or CABG, CABG was superior to GDMT. Although the primary outcome (death from any cause) was similar in the 2 treatment groups after an average of 5 years of follow-up, the data suggest the possibility that outcomes would differ if the follow-up were longer in duration; as a result, the study is being continued to provide follow-up for up to 10 years (371,372).

Only very limited data comparing PCI with medical therapy in patients with LV systolic dysfunction are available (356). In several ways, these data are suboptimal, in that many studies compared CABG with balloon angioplasty, many were retrospective, and many were based on cohort or registry data. Some of the studies demonstrated a similar survival rate in patients having CABG and PCI (359,451,490–492), whereas others showed that those undergoing CABG had better outcomes (320). The data that exist at present on revascularization in patients with CAD and LV systolic dysfunction are more robust for CABG than for PCI, although data from contemporary RCTs in this patient population are lacking. Therefore, the choice of revascularization in patients with CAD and LV systolic dysfunction is best based on clinical variables (e.g., coronary anatomy, presence of diabetes mellitus, presence of CKD), magnitude of LV systolic dysfunction, patient preferences, clinical judgment, and consultation between the interventional cardiologist and the cardiac surgeon.

3.9.5. Previous CABG

In patients with recurrent angina after CABG, repeat revascularization is most likely to improve survival in subjects at highest risk, such as those with obstruction of the proximal LAD artery and extensive anterior ischemia (373–381). Patients with ischemia in other locations and those with a patent LIMA to the LAD artery are unlikely to experience a survival benefit from repeat revascularization (380).

Cohort studies comparing PCI and CABG among post-CABG patients report similar rates of mid- and long-term survival after the 2 procedures (373,376–379,381,493). In the patient with previous CABG who is referred for revascularization for medically refractory ischemia, factors that may support the choice of repeat CABG include vessels unsuitable for PCI, number of diseased bypass grafts, availability of the IMA for grafting, chronically occluded coronary arteries, and good distal targets for bypass graft placement. Factors favoring PCI over CABG include limited areas of ischemia causing symptoms, suitable PCI targets, a patent graft to the LAD artery, poor CABG targets, and comorbid conditions.

3.9.6. Unstable Angina/Non–ST-Elevation Myocardial Infarction

The main difference between management of the patient with SIHD and the patient with UA/NSTEMI is that the impetus for revascularization is stronger in the setting of UA/NSTEMI, because myocardial ischemia occurring as part of an ACS is potentially life threatening, and associated anginal symptoms are more likely to be reduced with a revascularization procedure than with GDMT (494–496). Thus, the indications for revascularization are strengthened by the acuity of presentation, the extent of ischemia, and the ability to achieve full revascularization. The choice of revascularization method is generally dictated by the same considerations used to decide on PCI or CABG for patients with SIHD.

3.9.7. DAPT Compliance and Stent Thrombosis: Recommendation

CLASS III: HARM

1. **PCI with coronary stenting (BMS or DES) should not be performed if the patient is not likely to be able to tolerate and comply with DAPT for the appropriate duration of treatment based on the type of stent implanted (497–500). *(Level of Evidence: B)***

The risk of stent thrombosis is increased dramatically in patients who prematurely discontinue DAPT, and stent thrombosis is associated with a mortality rate of 20% to 45% (497). Because the risk of stent thrombosis with BMS is greatest in the first 14 to 30 days, this is the generally

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recommended minimum duration of DAPT therapy for these individuals. Consensus in clinical practice is to treat DES patients for at least 12 months with DAPT to avoid late (after 30 days) stent thrombosis (497,501). Therefore, the ability of the patient to tolerate and comply with at least 30 days of DAPT with BMS treatment and at least 12 months of DAPT with DES treatment is an important consideration in deciding whether to use PCI to treat patients with CAD.

3.10. TMR as an Adjunct to CABG

TMR has been used on occasion in patients with severe angina refractory to GDMT in whom complete revascularization cannot be achieved with PCI and/or CABG. Although the mechanism by which TMR might be efficacious in these patients is unknown (502,503), several RCTs of TMR as sole therapy demonstrated a reduction in anginal symptoms compared with intensive medical therapy alone (397–399,504–506). A single randomized multicenter comparison of TMR (with a holmium:YAG laser) plus CABG and CABG alone in subjects in whom some myocardial segments were perfused by arteries considered not amenable to grafting showed a significant reduction in perioperative mortality rate (1.5% versus 7.6%, respectively), and the survival benefit of the TMR–CABG combination was present after 1 year of follow-up (400). At the same time, a large retrospective analysis of data from the STS National Cardiac Database, as well as a study of 169 patients from the Washington Hospital Center who underwent combined TMR–CABG, showed no difference in adjusted mortality rate compared with CABG alone (401,507). In short, a TMR–CABG combination does not appear to improve survival compared with CABG alone. In selected patients, however, such a combination may be superior to CABG alone in relieving angina.

3.11. Hybrid Coronary Revascularization: Recommendations

CLASS IIa

1. Hybrid coronary revascularization (defined as the planned combination of LIMA-to-LAD artery grafting and PCI of ≥1 non-LAD coronary arteries) is reasonable in patients with 1 or more of the following (508–516) *(Level of Evidence: B)*:
   a. Limitations to traditional CABG, such as heavily calcified proximal aorta or poor target vessels for CABG (but amenable to PCI);
   b. Lack of suitable graft conduits;
   c. Unfavorable LAD artery for PCI (i.e., excessive vessel tortuosity or chronic total occlusion).

CLASS IIb

1. Hybrid coronary revascularization (defined as the planned combination of LIMA-to-LAD artery grafting and PCI of ≥1 non-LAD coronary arteries) may be reasonable as an alternative to multivessel PCI or CABG in an attempt to improve the overall risk–benefit ratio of the procedures. *(Level of Evidence: C)*

Hybrid coronary revascularization, defined as the planned combination of LIMA-to-LAD artery grafting and PCI of ≥1 non-LAD coronary arteries (515), is intended to combine the advantages of CABG (i.e., durability of the LIMA graft) and PCI (516). Patients with multivessel CAD (e.g., LAD and ≥1 non-LAD stenoses) and an indication for revascularization are potentially eligible for this approach. Hybrid revascularization is ideal in patients in whom technical or anatomic limitations to CABG or PCI alone may be present and for whom minimizing the invasiveness (and therefore the risk of morbidity and mortality) of surgical intervention is preferred (510) (e.g., patients with severe preexisting comorbidities, recent MI, a lack of suitable graft conduits, a heavily calcified ascending aorta, or a non-LAD coronary artery unsuitable for bypass but amenable to PCI, and situations in which PCI of the LAD artery is not feasible because of excessive tortuosity or chronic total occlusion).

Hybrid coronary revascularization may be performed in a hybrid suite in one operative setting or as a staged procedure (i.e., PCI and CABG performed in 2 different operative suites, separated by hours to 2 days, but typically during the same hospital stay). Because most hospitals lack a hybrid operating room, staged procedures are usually performed. With the staged procedure, CABG before PCI is preferred, because this approach allows the interventional cardiologist to 1) verify the patency of the LIMA-to-LAD artery graft before attempting PCI of other vessels and 2) minimize the risk of perioperative bleeding that would occur if CABG were performed after PCI (i.e., while the patient is receiving DAPT). Because minimally invasive CABG may be associated with lower graft patency rates compared with CABG performed through a midline sternotomy, it seems prudent to angiographically image all grafts performed through a minimally invasive approach to confirm graft patency (510).

To date, no RCTs involving hybrid coronary revascularization have been published. Over the past 10 years, several small, retrospective series of hybrid revascularization using minimally invasive CABG and PCI have reported low mortality rates (0 to 2%) and event-free survival rates of 83% to 92% at 6 to 12 months of follow-up. The few series that have compared the outcomes of hybrid coronary revascularization with standard CABG report similar outcomes at 30 days and 6 months (508–514).

4. Perioperative Management

4.1. Preoperative Antiplatelet Therapy: Recommendations

CLASS I

1. Aspirin (100 mg to 325 mg daily) should be administered to CABG patients preoperatively (517–519). *(Level of Evidence: B)*
2. In patients referred for elective CABG, clopidogrel and ticagrelor should be discontinued for at least 5 days before surgery (520–522) *(Level of Evidence: B)* and prasugrel for at least 7 days *(Level of Evidence: C)* to limit blood transfusions.
3. In patients referred for urgent CABG, clopidogrel and ticagrelor should be discontinued for at least 24 hours to reduce major bleeding complications (521,523–525). *(Level of Evidence: B)*

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4. In patients referred for CABG, short-acting intravenous glycoprotein IIb/IIIa inhibitors (eptifibatide or tirofiban) should be discontinued for at least 2 to 4 hours before surgery (526,527) and abciximab for at least 12 hours beforehand (528) to limit blood loss and transfusions. *(Level of Evidence: B)*

CLASS IIb

1. In patients referred for urgent CABG, it may be reasonable to perform surgery less than 5 days after clopidogrel or ticagrelor has been discontinued and less than 7 days after prasugrel has been discontinued. *(Level of Evidence: C)*

Nearly all patients with UA or recent MI in whom CABG is performed will be taking aspirin; CABG can be performed safely in these individuals, with only a modest increase in bleeding risk. Preoperative aspirin use reduces operative morbidity and mortality rates (517,518).

Although the use of thienopyridines (clopidogrel or prasugrel) is associated with improved outcomes in subjects with UA or NSTEMI (305,306), their use is associated with an increase in post-CABG bleeding and need for transfusions (520,522,529–533). The risk of major bleeding complications (i.e., pericardial tamponade or reoperation) is increased when CABG is performed <24 hours after clopidogrel's discontinuation (524,525). Conversely, no increase in bleeding or transfusions is noted when CABG is performed >5 days after clopidogrel has been stopped (529,532). The magnitude of bleeding risk when CABG is performed 1 to 4 days after the discontinuation of clopidogrel is less certain. Although the incidence of life-threatening bleeding does not appear to be significantly increased during this time, an increase in blood transfusions is likely (523,524,529,531). Accordingly, from the perspective of blood conservation, it is reasonable to delay elective CABG for ≥5 days after discontinuing clopidogrel. For patients requiring more urgent CABG, it can be performed >24 hours after clopidogrel has been stopped with little or no increased risk of major bleeding. Approximately two thirds of clopidogrel-treated patients undergo CABG <5 days after clopidogrel discontinuation (529,532), driven largely by concerns for patient stability, resource utilization, patient preference, and the confidence of the surgical team in managing hemostasis. Little experience with CABG in patients treated with prasugrel has been reported. In the TRITON-TIMI 38 (Trial to Assess Improvement in Therapeutic Outcomes by Optimizing Platelet Inhibition With Prasugrel Thrombolysis in Myocardial Infarction) trial, the incidence of CABG-related major bleeding was higher in prasugrel-treated patients than in those on clopidogrel (13.4% versus 3.2%; $p<0.001$) (533). When possible, therefore, CABG should be delayed for ≥7 days after prasugrel is discontinued (533).

Ticagrelor, an oral agent that binds reversibly to the platelet $P2Y_{12}$ receptor, provides faster, more effective, and more consistent inhibition of platelet aggregation and more rapid recovery of platelet function after discontinuation than clopidogrel (534). In the PLATO (Platelet Inhibition and Patient Outcomes) trial, 632 patients in the ticagrelor group and 629 in the clopidogrel group underwent CABG within 7 days of the last dose of study drug (521). Although the study protocol recommended waiting ≥5 days after stopping clopidogrel and 24 to 72 hours after ticagrelor, many patients underwent surgery before the recommended waiting times. The rates of major bleeding (59.3% with ticagrelor, 57.6% with clopidogrel) and transfusion requirements (55.7% with ticagrelor, 56.5% with clopidogrel) were similar. Furthermore, no difference in bleeding was noted between ticagrelor and clopidogrel with respect to time from last dose of study drug, even when CABG was performed 1, 2, or 3 days after discontinuation. On the basis of these data, it does not appear that the more rapid recovery of platelet function seen in ticagrelor pharmacokinetic studies translates to a lower risk of bleeding or less need for transfusion compared with clopidogrel when CABG is performed early (i.e., <5 days) after drug discontinuation.

4.2. Postoperative Antiplatelet Therapy: Recommendations

CLASS I

1. If aspirin (100 mg to 325 mg daily) was not initiated preoperatively, it should be initiated within 6 hours postoperatively and then continued indefinitely to reduce the occurrence of SVG closure and adverse cardiovascular events (519,535,536). *(Level of Evidence: A)*

CLASS IIa

1. For patients undergoing CABG, clopidogrel 75 mg daily is a reasonable alternative in patients who are intolerant of or allergic to aspirin. *(Level of Evidence: C)*

See Online Data Supplement 23 for additional data on postoperative antiplatelet therapy.

Aspirin significantly improves SVG patency rates, particularly during the first postoperative year. Because arterial graft patency rates are high even in the absence of antiplatelet therapy, the administration of such therapy has not shown an improvement. Aspirin administration before CABG offers no improvement in subsequent SVG patency compared with its early postoperative initiation (535). Prospective controlled trials have demonstrated a graft patency benefit when aspirin was started 1, 7, or 24 hours after operation (103,537); in contrast, the benefit of postoperative aspirin on SVG patency was lost when it was initiated >48 hours after surgery (538).

Dosing regimens ranging from 100 mg daily to 325 mg 3 times daily appear to be efficacious (539). As the grafted recipient's coronary arterial luminal diameter increases, SVG patency rates improve, and the relative advantage of aspirin over placebo is reduced (540). Although aspirin doses of <100 mg daily have been used for prevention of adverse events in patients with CAD, they may be less efficacious than higher doses in optimizing SVG patency (541). Enteric-coated aspirin, 75 mg, has been associated with suboptimal inhibition of platelet aggregation in 44% of patients with stable cardiovascular disease, suggesting that soluble aspirin may be preferred if low-dose aspirin is used

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(542). When given within 48 hours after CABG, aspirin has been shown to reduce subsequent rates of mortality, MI, stroke, renal failure, and bowel infarction (519).

Although ticlopidine is efficacious at inhibiting platelet aggregation, it offers no advantage over aspirin except as an alternative in the truly aspirin-allergic patient (543). In addition, its use may be associated with potentially life-threatening neutropenia, a rare adverse effect, such that white blood cell counts should be monitored repetitively after initiating it. Dipyridamole and warfarin add nothing to the effect of aspirin on SVG patency (544,545), and use of the latter may be associated with an increased risk for bleeding compared with antiplatelet agents (546).

Clopidogrel is associated with fewer adverse effects than ticlopidine. Severe leukopenia occurs very rarely (546,547). A subset analysis of CABG patients from the CURE (Clopidogrel in Unstable Angina to Prevent Recurrent Ischemic Events) trial suggested that clopidogrel reduced the occurrence of cardiovascular death, MI, and stroke (14.5%) compared with placebo (16.2%). This benefit occurred primarily before surgery, however, and after CABG a difference in primary endpoints between groups was not demonstrable. Clopidogrel was stopped a median of 10 days before surgery and was restarted postoperatively in 75.3% of patients assigned to receive it. All patients received aspirin, 75 mg to 325 mg daily, but the details of aspirin administration in the study groups were not described (530).

4.3. Management of Hyperlipidemia: Recommendations

CLASS I

1. All patients undergoing CABG should receive statin therapy, unless contraindicated (545,548–559). *(Level of Evidence: A)*
2. In patients undergoing CABG, an adequate dose of statin should be used to reduce LDL cholesterol to less than 100 mg/dL and to achieve at least a 30% lowering of LDL cholesterol (548–552). *(Level of Evidence: C)*

CLASS IIa

1. In patients undergoing CABG, it is reasonable to treat with statin therapy to lower the LDL cholesterol to less than 70 mg/dL in very high-risk* patients (549–551,561–563). *(Level of Evidence: C)*
2. For patients undergoing urgent or emergency CABG who are not taking a statin, it is reasonable to initiate high-dose statin therapy immediately (564). *(Level of Evidence: C)*

CLASS III: HARM

1. Discontinuation of statin or other dyslipidemic therapy is not recommended before or after CABG in patients without adverse reactions to therapy (565–567). *(Level of Evidence: B)*

See Online Data Supplement 24 for additional data on management of hyperlipidemia.

*Presence of established cardiovascular disease plus 1) multiple major risk factors (especially diabetes), 2) severe and poorly controlled risk factors (especially continued cigarette smoking), 3) multiple risk factors of the metabolic syndrome (especially high triglycerides ≥200 mg/dL plus non–high-density lipoprotein cholesterol ≥130 mg/dL with low high-density lipoprotein cholesterol [<40 mg/dL]), and 4) acute coronary syndromes.

In patients with CAD, treatment of hyperlipidemia with therapeutic lifestyle changes and medications reduces the risk of nonfatal MI and death. The goal of such therapy is to reduce the LDL cholesterol level to <100 mg/dL (563). Statins are the most commonly prescribed agents for achieving this goal (563).

Studies of lipid-lowering therapy in CABG patients have demonstrated that lowering LDL cholesterol with statins influences post-CABG outcomes, and "aggressive" LDL cholesterol lowering (to 60 to 85 mg/dL) is associated with a reduced rate of graft atherosclerosis and repeat revascularization compared with only "moderate" lowering (130 to 140 mg/dL) (545,556). In the latter study, both groups of subjects initially received lovastatin at different doses (40 mg in the "aggressive" lowering group versus 2.5 mg in the "moderate" group), and cholestyramine was added if LDL cholesterol goals were not met with lovastatin alone. Of note, patients were maintained on therapy for ≥1 year, and as many as 11 years, after CABG.

The PROVE IT TIMI-22 (Pravastatin or Atorvastatin Evaluation and Infection Therapy: Thrombolysis in Myocardial Infarction) trial randomly assigned patients with ACS, a minority of whom had previous CABG, to intensive (LDL cholesterol goal <70 mg/dL) versus standard (LDL cholesterol goal <100 mg/dL) lipid-lowering therapy. The benefit of intensive therapy (a reduction in death, MI, recurrent UA, repeat revascularization, or stroke) was observed within 30 days (561). In the occasional subject who cannot take statins, alternative hypolipidemic agents, such as bile acid sequestrants, niacin, and fibrates, should be considered, in accordance with National Cholesterol Education Program: Adult Treatment Panel III guidelines (563).

4.3.1. Timing of Statin Use and CABG Outcomes

As noted, the benefits of post-CABG LDL lowering with statins have been reported previously, but no prospective studies of the impact of preoperative LDL cholesterol lowering on post-CABG outcomes are available. One small randomized comparison of preoperative placebo and a statin (initiated 1 week before CABG) showed a reduction in elevated perioperative cardiac biomarkers with statin therapy (554). Several nonrandomized, retrospective studies have noted an association between preoperative statin use and reduced rates of postoperative nonfatal MI and death (553,555,557–559). In addition, preoperative statin use has been associated with reduced rates of postoperative atrial fibrillation (AF) (571,572), neurological dysfunction (555, 573,574), renal dysfunction (575), and infection (576). Untreated hyperlipidemic patients have been shown to have a higher risk of post-CABG events than that of treated hyperlipidemic patients and those with normal serum lipid concentrations (567). In patients undergoing CABG who are not on statin therapy or at LDL goal, it seems reasonable to initiate intensive statin therapy preoperatively (i.e., no later than 1 week before surgery).

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Postoperatively, statin use should be resumed when the patient is able to take oral medications and should be continued indefinitely. Patients in whom statins were discontinued after CABG have been shown to have a higher mortality rate than those in whom statins were continued postoperatively (566).

4.3.1.1. POTENTIAL ADVERSE EFFECTS OF PERIOPERATIVE STATIN THERAPY

The most common adverse effects reported with statin use are myopathy and hepatotoxicity. Muscle aches have been reported in about 5% of patients treated with statins, although several pooled analyses of RCTs have shown a similar rate of muscle aches with placebo (577). Myositis, defined as muscle pain with a serum creatine kinase >10 times the upper limit of normal, occurs in 0.1% to 0.2% of statin users, and rhabdomyolysis occurs in 0.02% (578,579). In addition, approximately 2% of patients are observed to have elevated liver enzymes (i.e., alanine and aspartate transaminases) in the weeks to months after statin initiation, but no data are available to suggest that these elevations are associated with permanent hepatotoxicity or an increased risk of hepatitis. Nonetheless, the presence of active or chronic liver disease is a contraindication to statin use, and patients initiated on a statin should be monitored for the development of myositis or rhabdomyolosis, either of which would mandate its discontinuation (580).

4.4. Hormonal Manipulation: Recommendations

CLASS I

1. Use of continuous intravenous insulin to achieve and maintain an early postoperative blood glucose concentration less than or equal to 180 mg/dL while avoiding hypoglycemia is indicated to reduce the incidence of adverse events, including deep sternal wound infection, after CABG (581–583). *(Level of Evidence: B)*

CLASS IIb

1. The use of continuous intravenous insulin designed to achieve a target intraoperative blood glucose concentration less than 140 mg/dL has uncertain effectiveness (584–586). *(Level of Evidence: B)*

CLASS III: HARM

1. Postmenopausal hormonal therapy (estrogen/progesterone) should not be administered to women undergoing CABG (587–589). *(Level of Evidence: B)*

4.4.1. Glucose Control

Hyperglycemia often occurs during and after CABG, particularly when CABG is performed on pump. Intraoperative hyperglycemia is associated with an increased morbidity rate in patients with diabetes (590) and with excess mortality in patients with and without diabetes (591). Hyperglycemia during CPB is an independent risk factor for death in patients undergoing cardiac surgery. A retrospective observational study of 409 cardiac surgical patients identified intraoperative hyperglycemia as an independent risk factor for perioperative complications, including death, and calculated a 34% increased likelihood of postoperative complications for every 20-mg/dL increase in blood glucose concentration >100 mg/dL during surgery (592). An RCT of critically ill patients, many of whom had high-risk cardiac surgery, found reduced morbidity and mortality rates in those whose blood glucose was tightly controlled (583), and follow-up of these subjects showed that this benefit persisted for up to 4 years (582).

The Portland Diabetes Project, begun in 1992, was the first large study to elucidate the detrimental effects of hyperglycemia in relation to CABG outcomes. This prospective observational study described the evolution in management of cardiac surgical patients with diabetes mellitus from a strategy of intermittent subcutaneous injections of insulin to one of continuous intravenous insulin infusion with decreasing target glucose concentrations. As this management strategy evolved, the upper target serum glucose concentrations declined from 200 mg/dL to 110 mg/dL, with which significant reductions in operative and cardiac-related death (arrhythmias and acute ventricular failure) were noted (581). In addition, continuous intravenous insulin to maintain a serum glucose concentration of 120 mg/dL to 160 mg/dL resulted in a reduced incidence of deep sternal wound infection (593,594). As a result, most centers now emphasize tight glucose control (target serum glucose concentration ≤180 mg/dL, accomplished with a continuous intravenous insulin infusion) during surgery and until the morning of the third postoperative day.

Whether extremely tight intraoperative glucose control can further reduce morbidity or mortality rate is controversial. A prospective trial from the Mayo Clinic randomly assigned 400 patients to intensive treatment (continuous insulin infusion during surgery) or conventional treatment (insulin given only for a glucose concentration >200 mg/dL) (586). Postoperative ICU management was similar in the 2 groups. Although no difference was noted between groups in a composite endpoint of death, deep sternal wound infection, prolonged ventilation, cardiac arrhythmias, stroke, or renal failure within 30 days of surgery, intensive treatment caused an increased incidence of death and stroke, thereby raising concerns about this intervention (586). In a prospective RCT in 381 CABG patients without diabetes, those with an intraoperative blood glucose concentration >100 mg/dL were assigned to an insulin infusion or no treatment (584). Those receiving insulin had lower intraoperative glucose concentrations, but no difference between groups was observed in the occurrence of new neurological, neuro-ophthalmologic, or neurobehavioral deficits or neurology-related deaths. Of note, no difference in need for inotropic support, hospital length of stay, or operative mortality rate was seen between the groups (584). A retrospective analysis of intraoperative and postoperative ICU glucose concentrations in >4,300 patients undergoing cardiac surgery at the Cleveland Clinic observed that a blood glucose concentration >200 mg/dL in the operating room or ICU was associated with worse outcomes, but intraoperative glucose concentrations ≤140 mg/dL were not associated with improved outcomes compared with severe

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hyperglycemia, despite infrequent hypoglycemia. Diabetic status did not influence the effects of hyperglycemia (585). In short, until additional information is available, extremely tight intraoperative glucose control is not recommended.

Although the management of blood glucose before surgery in patients with and without diabetes mellitus is not well studied, an increased incidence of adverse outcomes has been noted in patients with poor preoperative glycemic control (593,595). As a result, most centers now attempt to optimize glucose control before surgery, attempting to achieve a target glucose concentration ≤180 mg/dL with continuous intravenous insulin. Measuring preoperative hemoglobin A1c concentrations may be helpful in assessing the adequacy of preoperative glycemic control and identifying patients at risk for postoperative hyperglycemia (596).

4.4.2. Postmenopausal Hormone Therapy

Postmenopausal hormone therapy was shown previously to reduce the risk of cardiac-related death. However, more contemporary published RCTs have suggested that it may have adverse cardiovascular effects. The Women's Health Initiative randomly assigned >16,000 healthy postmenopausal women to placebo or continuous combined estrogen–progestin therapy. Hormone therapy was discontinued early because of an increased risk of breast cancer in those receiving it. Additionally, subjects receiving it had an increased incidence of cardiac ischemic events (29% increase, mainly nonfatal MI), stroke, and venous thromboembolism (588). A secondary prevention trial, HERS (Heart and Estrogen/Progestin Replacement Study), randomly assigned 2,763 postmenopausal women with known CAD to continuous estrogen/progestin or placebo, after which they were followed up for a mean of 4.1 years (587). No difference in the primary endpoints of nonfatal MI and CAD death was noted, but those receiving hormone therapy had a greater incidence of deep venous thrombosis and other thromboembolic events. This predisposition to thrombosis has raised concerns that hormone therapy may cause adverse events at the time of CABG. A prospective RCT comparing hormone therapy to placebo in postmenopausal women after CABG was initiated in 1998 but was stopped when the Women's Health Initiative trial results were reported (589). Eighty-three subjects were enrolled, and 45 underwent angiographic follow-up at 42 months. Angiographic progression of CAD in nonbypassed coronary arteries was greater in patients receiving hormone therapy, although less progression of disease was observed in SVGs. Postoperative angioplasty was performed in 8 hormone therapy patients and only 1 placebo subject ($p<0.05$). On the basis of these data, it is not recommended that postmenopausal hormone therapy be initiated in women undergoing CABG, and it may be reasonable to discontinue it in those scheduled for elective CABG.

4.4.3. CABG in Patients With Hypothyroidism

Subclinical hypothyroidism (thyroid-stimulating hormone concentration, 4.50 mIU/L to 19.9 mIU/L) occurs commonly in patients with CAD. In a meta-analysis of >55,000 subjects with CAD, those with subclinical hypothyroidism did not have an increase in total deaths, but the CAD mortality rate was increased, particularly in those with thyroid-stimulating hormone concentrations >10 mIU/L (597).

The risks of CABG in hypothyroid patients are poorly defined. A retrospective study of hypothyroid patients undergoing CABG had a higher incidence of heart failure and gastrointestinal complications and a lower incidence of postoperative fever than did members of a matched euthyroid group (598). Patients with subclinical hypothyroidism may be at increased risk for developing AF after CABG (599), and 1 study even suggested that triiodothyronine supplementation in patients undergoing CABG (including those who are euthyroid) decreased the incidence of postoperative AF (600). Conversely, controlled studies of triiodothyronine in subjects undergoing CABG have shown no benefit (601,602). Rarely, patients may develop severe hypothyroidism after CABG, which manifests as lethargy, prolonged required ventilation, and hypotension (603). Thyroid replacement is indicated in these individuals.

4.5. Perioperative Beta Blockers: Recommendations

CLASS I

1. Beta blockers should be administered for at least 24 hours before CABG to all patients without contraindications to reduce the incidence or clinical sequelae of postoperative AF (604–608,608a–608c). *(Level of Evidence: B)*
2. Beta blockers should be reinstituted as soon as possible after CABG in all patients without contraindications to reduce the incidence or clinical sequelae of AF (604–608,608a–608c). *(Level of Evidence: B)*
3. Beta blockers should be prescribed to all CABG patients without contraindications at the time of hospital discharge. *(Level of Evidence: C)*

CLASS IIa

1. Preoperative use of beta blockers in patients without contraindications, particularly in those with an LVEF greater than 30%, can be effective in reducing the risk of in-hospital mortality (609–611). *(Level of Evidence: B)*
2. Beta blockers can be effective in reducing the incidence of perioperative myocardial ischemia (612–615). *(Level of Evidence: B)*
3. Intravenous administration of beta blockers in clinically stable patients unable to take oral medications is reasonable in the early postoperative period (616). *(Level of Evidence: B)*

CLASS IIb

1. The effectiveness of preoperative beta blockers in reducing in-hospital mortality rate in patients with LVEF less than 30% is uncertain (609,617). *(Level of Evidence: B)*

See Online Data Supplement 25 for additional data on beta blockers.

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Because beta blockers have been shown to reduce the incidence of postoperative AF in CABG patients who are receiving them preoperatively (604,605,608) (Section 5.2.5), the STS and AHA recommend that they be administered preoperatively to all patients without contraindications and then be continued postoperatively (618,619). Despite this recommendation, uncertainty exists about their efficacy in subjects not receiving them preoperatively; in this patient population, their use appears to lengthen hospital stay and not to reduce the incidence of postoperative AF (604,607). Their efficacy in preventing or treating perioperative myocardial ischemia is supported by the results of observational studies and small RCTs (612–614). Although a meta-analysis of available data did not show an improvement in outcomes with perioperative beta blockers (615), observational analyses suggest that preoperative beta-blocker use is associated with a reduction in perioperative deaths (609–611). Another analysis of data from 629,877 patients reported a mortality rate of 2.8% in those receiving beta blockers versus 3.4% in those not receiving them (609).

Few data are available on the pharmacokinetic disposition of beta blockers in the early postoperative period, when an alteration in gastrointestinal perfusion may adversely affect their absorption after oral administration. An RCT demonstrated a significant reduction in the incidence of postoperative AF when a continuous intravenous infusion of metoprolol was used rather than oral administration (616).

The efficacy of beta-blocker use in CABG patients after hospital discharge is uncertain, as data from 2 RCTs and 1 large detailed observational analysis suggest that they exert no benefit over 2 years postoperatively (621–623). In contrast, some observational analyses have reported that they are, in fact, efficacious in high-risk subgroups (e.g., those with perioperative myocardial ischemia or elderly subjects with heart failure) (624). A contemporary analysis of prescription data from 3,102 Canadian patients, 83% of whom were prescribed a beta blocker at the time of discharge, reported that those receiving beta blockers had a reduced mortality rate during a mean follow-up of 75 months (625). Of note, improved survival was noted in all patient subgroups receiving beta blockers, even including those without perioperative myocardial ischemia or heart failure.

4.6. ACE Inhibitors/ARBs: Recommendations

CLASS I

1. ACE inhibitors and ARBs given before CABG should be reinstituted postoperatively once the patient is stable, unless contraindicated (622,626,627). *(Level of Evidence: B)*
2. ACE inhibitors or ARBs should be initiated postoperatively and continued indefinitely in CABG patients who were not receiving them preoperatively, who are stable, and who have an LVEF less than or equal to 40%, hypertension, diabetes mellitus, or CKD, unless contraindicated (622,627,627a,627b). *(Level of Evidence: A)*

CLASS IIa

1. It is reasonable to initiate ACE inhibitors or ARBs postoperatively and to continue them indefinitely in all CABG patients who were not receiving them preoperatively and are considered to be at low risk (i.e., those with a normal LVEF in whom cardiovascular risk factors are well controlled), unless contraindicated (622,627–630). *(Level of Evidence: B)*

CLASS IIb

1. The safety of the preoperative administration of ACE inhibitors or ARBs in patients on chronic therapy is uncertain (631–636). *(Level of Evidence: B)*
2. The safety of initiating ACE inhibitors or ARBs before hospital discharge is not well established (622,628,630,640). *(Level of Evidence: B)*

See Online Data Supplements 26 and 27 for additional data on ACE inhibitors.

ACE inhibitors and ARBs are known to exert cardiovasculoprotective actions, particularly in subjects with LV systolic dysfunction, hypertension, diabetes mellitus, or chronic renal insufficiency (626). Nonetheless, the safety and effectiveness of preoperative ACE inhibitors and ARBs in patients undergoing cardiac or noncardiac surgery is uncertain (638) because their administration has been associated with intraoperative hypotension as well as a blunted response to pressors and inotropic agents after induction of anesthesia. Of particular concern during cardiac surgery is their reported association with severe hypotension after CPB (so-called vasoplegia syndrome) and postoperative renal dysfunction (631,639).

Although it has been postulated that these agents may protect against the development of postoperative AF, published studies have reached conflicting conclusions in this regard (634,636). The safety and efficacy of ACE inhibitors and ARBs after CABG in previously naïve low- to moderate-risk patients (i.e., subjects without diabetes mellitus or renal insufficiency and with or without asymptomatic moderate LV systolic dysfunction) are uncertain; furthermore, ACE inhibitors and ARBs must be used with caution in these subjects. They should not be instituted in the immediate postoperative period if the systolic arterial pressure is <100 mm Hg or if the patient develops hypotension in the hospital after receiving them. The IMAGINE (Ischemia Management With Accupril Post Bypass Graft via Inhibition of Angiotensin Converting Enzyme) study failed to show a beneficial effect of postoperative ACE inhibitor therapy 3 years after CABG, instead noting an increase in adverse events, particularly recurrent angina in the first 3 months of therapy (630). A subanalysis of the data from patients enrolled in EUROPA (European Trial on the Reduction of Cardiac Events with Perindopril in Stable Coronary Artery Disease) with previous revascularization (CABG or PCI no sooner than 6 months before enrollment) suggested a primary and secondary prevention benefit over a 4.2-year follow-up period; however, an analysis of the data from almost 3,000 patients in the

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PREVENT IV (PRoject of Ex-vivo Vein graft ENgineering via Transfection) trial, all of whom were taking either ACE inhibitors or ARBs at the time of hospital discharge, failed to demonstrate a significant reduction in death or MI after 2 years of follow-up in "ideal" candidates (based on ACCF/AHA/HRS guidelines) (HR: 0.87; 95% CI: 0.52 to 1.45; p=NS), whereas significance was achieved in "non-ideal" candidates (HR: 1.64; 95% CI: 1.00 to 2.68; p=0.05) (608,622,628,640).

4.7. Smoking Cessation: Recommendations

CLASS I

1. All smokers should receive in-hospital educational counseling and be offered smoking cessation therapy during CABG hospitalization (642–644). *(Level of Evidence: A)*

CLASS IIb

1. The effectiveness of pharmacological therapy for smoking cessation offered to patients before hospital discharge is uncertain. *(Level of Evidence: C)*

See Online Data Supplement 28 for additional data on smoking cessation.

Smoking cessation after CABG is associated with a substantial reduction in subsequent MACE, including MI and death. Data from the randomized portion of the CASS study showed 10-year survival rates of 82% among the 468 patients who quit smoking after CABG and only 77% in the 312 who continued to smoke (p=0.025) (645). Those who continued to smoke were more likely to have recurrent angina and to require repeat hospitalization. Data from the CASS registry demonstrated 5-year mortality rates of 22% for those who continued to smoke and only 15% for those who successfully quit smoking after CABG (RR: 1.55; 95% CI: 1.29 to 1.85) (646). Similar favorable outcomes with smoking cessation were reported from the MRFIT (Multiple Risk Factor Intervention Trial), in which the impact of smoking cessation on MACE was assessed after 10.5 years of follow-up in 12,866 men; the risk of death was greater among smokers than nonsmokers (RR: 1.57) (647). Notably, the risk of dying from cardiac causes was lower for those who successfully quit than for nonquitters after only 1 year of smoking cessation (RR: 0.63), and it remained so in those who quit for at least the first 3 years of the study (RR: 0.38) (647). The beneficial effects of smoking cessation after CABG seem to be durable during long-term follow-up (i.e., even 30 years postoperatively) (648–650). In fact, smoking cessation was associated with a reduction in mortality rate of greater magnitude than that resulting from any other treatment or intervention after CABG (649). In these long-term follow-up studies, patients who continued to smoke had significantly higher rates of MI, reoperation, and death.

Smoking is a powerful independent predictor of sudden cardiac death in patients with CAD (HR: 2.47; 95% CI: 1.46 to 4.19). It has been associated with accelerated disease and occlusion of SVGs as well as endothelial dysfunction of arterial grafts (651–653). Compared with nonsmokers, subjects who are smoking at the time of CABG more often have pulmonary complications that require prolonged postoperative intubation and a longer ICU stay as well as postoperative infections (654–656). Even smokers who quit just before CABG have fewer postoperative complications than those who continued to smoke (654). As a result, all smokers referred for CABG should be counseled to quit smoking before surgery.

Smoking cessation seems to be especially beneficial for patients hospitalized with ACS who then require CABG (644,657). Independent predictors of continued nonsmoking 1 year after CABG included <3 previous attempts to quit (OR: 7.4; 95% CI: 1.9 to 29.1), >1 week of preoperative nonsmoking (OR: 10.0; 95% CI: 2.0 to 50), a definite intention to quit smoking (OR: 12.0; 95% CI: 2.6 to 55.1), and no difficulty with smoking cessation while in the hospital (OR: 9.6; 95% CI: 1.8 to 52.2) (658). Aggressive smoking cessation intervention directed at patients early after post-CABG discharge appears to be more effective than a conservative approach (642). In a systematic review of 33 trials of smoking cessation, counseling that began during hospitalization and included supportive contacts for >1 month after hospital discharge increased the rates of smoking cessation (OR: 1.65; 95% CI: 1.44 to 1.90), whereas the use of pharmacotherapy did not improve abstinence rates (643). These findings are supported by a 2009 RCT comparing intensive or minimal smoking cessation intervention in patients hospitalized for CABG or acute MI (644). In this trial, the 12-month self-reported rate of abstinence was 62% among patients randomly assigned to the intensive program and 46% among those randomly allocated to the minimal intervention (OR: 2.0; 95% CI: 1.2 to 3.1). Overall, a higher rate of continuous abstinence was observed in patients undergoing CABG than in those who had sustained an MI. Interestingly, the rates of abstinence were lower in subjects who used pharmacotherapy regardless of the intervention group (OR: 0.3; 95% CI: 0.2 to 0.5) (644).

Seven first-line pharmacological treatments are available for smoking cessation therapy, including 5 nicotine-replacement therapies; the antidepressant bupropion; and varenicline, a partial agonist of the $\alpha_4\beta_2$ subtype of the nicotinic acetylcholine receptor (659–661). The data supporting the use and timing of nicotine-replacement therapy after CABG are unclear. One study from a large general practice database reported no increased risk of MI, stroke, or death with nicotine-replacement therapy (662), whereas a retrospective case–control study of critically ill patients reported a higher in-hospital mortality rate in those receiving nicotine replacement (20% versus 7%; p=0.0085). Despite adjusting for the severity of illness, nicotine-replacement therapy was an independent predictor of in-hospital mortality (OR: 24.6; 95% CI: 3.6 to 167.6; p=0.0011) (663). Similarly, in a cohort study of post-CABG patients, nicotine-replacement therapy was shown

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to be an independent predictor of in-hospital mortality after adjusting for baseline characteristics (OR: 6.06; 95% CI: 1.65 to 22.21) (663,664). Additional studies are needed to determine the safety of nicotine-replacement therapy in smokers undergoing CABG as well as the optimal time at which to begin such therapy postoperatively.

4.8. Emotional Dysfunction and Psychosocial Considerations: Recommendation

CLASS IIa

1. Cognitive behavior therapy or collaborative care for patients with clinical depression after CABG can be beneficial to reduce objective measures of depression (665–669). *(Level of Evidence: B)*

The negative impact of emotional dysfunction on risk of morbidity and mortality after CABG is well recognized. In a multivariate analysis of elderly patients after CABG, the 2 most important predictors of death were a lack of social participation and a lack of religious strength (670). Social isolation is associated with increased risk of death in patients with CAD (671), and treatment may improve outcomes (672). The most carefully studied mood disorder, depression, occurs commonly after CABG. Several studies have shown that the primary predictor of depression after CABG is its presence before CABG and that only rarely does CABG cause depression in patients who were not depressed beforehand. In 1 report, half the patients who were depressed before CABG were not depressed afterward, and only 9% of subjects who were not depressed before CABG developed depression postoperatively (673). The prevalence of depression at 1 year after CABG was 33%, which is similar to the prevalence in those undergoing other major operations. Patients with stronger perceptions of control of their illness were less likely to be depressed or anxious after CABG (674). No difference in the incidence of mood disturbances was noted when off-pump and on-pump CABG were compared (675).

4.8.1. Effects of Mood Disturbance and Anxiety on CABG Outcomes

Depression is an important risk factor for the development and progression of CAD. In fact, it is a more important predictor of the success of cardiac rehabilitation than many other functional cardiac variables (676). Both the presence of depressive symptoms before CABG and the postoperative worsening of these symptoms correlate with poorer physical and psychosocial functioning and poorer quality of life after CABG (677). In a study of 440 patients who underwent CABG, the effects of both preoperative anxiety and depression (as defined by the Depression Anxiety and Stress Scale) on mortality rate were assessed for a median of 5 years postoperatively (678). Interestingly, preoperative anxiety was associated with a significantly increased risk of death (HR: 1.88; 95% CI: 1.12 to 3.37; $p=0.02$), whereas preoperative depression was not (678). In a multivariate analysis of 817 patients at Duke University Medical Center, severe depression (assessed using the Center for Epidemiological Studies–Depression scale before surgery and 6 months postoperatively (665) was associated with increased risk of death (HR: 2.4; 95% CI: 1.4 to 4.0), as was mild or moderate depression that persisted at 6 months (HR: 2.2; 95% CI: 1.2 to 4.2). In another study of 309 subjects followed up for ≤1 year after CABG, those with diagnostic criteria for a major depressive disorder before discharge were nearly 3 times as likely to have a cardiac event, such as heart failure requiring hospitalization, MI, cardiac arrest, PCI, repeat CABG, or cardiac death (666). Finally, depression after CABG is an important predictor of the recurrence of angina during the first 5 postoperative years (666,673).

4.8.2. Interventions to Treat Depression in CABG Patients

The Bypassing the Blues investigators identified 302 patients who were depressed before CABG and 2 weeks after discharge (668). They were randomly assigned to 8 months of telephone-delivered collaborative care (150 patients) or "usual care" (152 patients). The 2 groups were compared with each other and also to another group of 151 randomly selected nondepressed post-CABG patients. At 8 month follow-up, the collaborative care group showed an improvement in quality of life and physical functioning and were more likely to report a >50% decline in the Hamilton Rating Score for Depression than the usual care group (50.0% versus 29.6%; $p<0.001$). Men were more likely to benefit from the intervention (668,669). In another study, 123 patients who met the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, criteria for major or minor depression within 1 year of CABG were randomly assigned to 12 weeks of cognitive behavior therapy, 12 weeks of supportive stress management, or usual care (667). Both interventions were efficacious for treating depression after CABG, and cognitive behavior therapy had the most durable effects on depression and several secondary psychological outcome variables (667). Thus, both collaborative intervention and cognitive behavior therapy are effective for treating depression in patients after CABG. Given that depression is associated with adverse outcomes after CABG, it is likely that these interventions also may lead to reduced rates of morbidity and mortality.

4.9. Cardiac Rehabilitation: Recommendation

CLASS I

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (679–681,681a–681d). *(Level of Evidence: A)*

See Online Data Supplement 29 for additional data on cardiac rehabilitation.

Cardiac rehabilitation, including early ambulation during hospitalization, outpatient prescriptive exercise training, and education, reduces risk of death in survivors of MI (682–684). Beginning 4 to 8 weeks after CABG, 3-times-weekly education and exercise sessions for 3 months are associated with a 35% increase in exercise tolerance

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(p=0.0001), a slight (2%) (p=0.05) increase in high-density lipoprotein cholesterol, and a 6% reduction in body fat (p=0.002) (421). Exercise training is a valuable adjunct to dietary modification of fat and total caloric intake in maximizing the reduction of body fat while minimizing the reduction of lean body mass. Aerobic training improves volume of maximum oxygen consumption at 6 months compared with moderate continuous training (p<0.001) (685).

After hospital discharge, CABG patients were randomly assigned to standard care (n=109) or standard care plus rehabilitation (n=119). At 5 years, the groups were similar in symptoms, medication use, exercise capacity, and depression scores, but rehabilitated patients reported better physical mobility, better perceived health, and better perceived overall life situation. A larger proportion of the rehabilitated patients were working at 3 years, although this difference disappeared with longer follow-up (679). Subjects who sustained an MI followed by CABG had greater improvement in exercise tolerance after rehabilitation than did those who had an MI alone. Improvement was sustained for 2 years (686). Observational studies have reported that cardiac events are reduced with rehabilitation after revascularization (680).

In many CABG patients, initiation of rehabilitation is a substantial hurdle. Medically indigent patients seem to have rehabilitation compliance and benefit rates similar to those of insured or private-paying patients if rehabilitation is initiated promptly and is structured appropriately (687). In addition to contributing to a patient's sense of well-being, participation in cardiac rehabilitation offers an economic benefit. During a 3-year (mean: 21 months) follow-up after CABG or another coronary event, per capita hospitalization charges were $739 lower for rehabilitated patients compared with nonparticipants (688). Post-CABG patients are more likely to resume sexual activity than are survivors of MI. Anticipatory and proactive advice by the physician or surgeon on the safety of resumption of sexual activity as the patient reengages in other daily activities is beneficial (682).

Recommendations for intensive risk-reduction therapies for patients with established coronary and other atherosclerotic vascular disease are detailed in the "AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update" (689). This updated guideline includes recommendations on smoking, blood pressure control, lipid management, physical therapy, weight management, type 2 diabetes management, antiplatelet agents and anticoagulants, renin–angiotensin–aldosterone system blockers (ACE inhibitors and ARBs), beta blockers, influenza vaccination, depression, and cardiac rehabilitation.

4.10. Perioperative Monitoring

4.10.1. Electrocardiographic Monitoring: Recommendations

CLASS I

1. Continuous monitoring of the electrocardiogram for arrhythmias should be performed for at least 48 hours in all patients after CABG (606,690,691). *(Level of Evidence: B)*

CLASS IIa

1. Continuous ST-segment monitoring for detection of ischemia is reasonable in the intraoperative period for patients undergoing CABG (53,692–694). *(Level of Evidence: B)*

CLASS IIb

1. Continuous ST-segment monitoring for detection of ischemia may be considered in the early postoperative period after CABG (613, 690,695–698). *(Level of Evidence: B)*

4.10.2. Pulmonary Artery Catheterization: Recommendations

CLASS I

1. Placement of a pulmonary artery catheter (PAC) is indicated, preferably before the induction of anesthesia or surgical incision, in patients in cardiogenic shock undergoing CABG. *(Level of Evidence: C)*

CLASS IIa

1. Placement of a PAC can be useful in the intraoperative or early postoperative period in patients with acute hemodynamic instability (699–704). *(Level of Evidence: B)*

CLASS IIb

1. Placement of a PAC may be reasonable in clinically stable patients undergoing CABG after consideration of baseline patient risk, the planned surgical procedure, and the practice setting (699–704). *(Level of Evidence: B)*

4.10.3. Central Nervous System Monitoring: Recommendations

CLASS IIb

1. The effectiveness of intraoperative monitoring of the processed electroencephalogram to reduce the possibility of adverse recall of clinical events or for detection of cerebral hypoperfusion in CABG patients is uncertain (705–707). *(Level of Evidence: B)*
2. The effectiveness of routine use of intraoperative or early postoperative monitoring of cerebral oxygen saturation via near-infrared spectroscopy to detect cerebral hypoperfusion in patients undergoing CABG is uncertain (708–710). *(Level of Evidence: B)*

See Online Data Supplement 30 for additional data on central nervous system monitoring.

Requirements for basic perioperative monitoring in patients undergoing CABG, including heart rate, blood pressure, peripheral oxygen saturation, and body temperature, are well accepted. Additional intraoperative standards established by the American Society of Anesthesiologists, including the addition of end-tidal carbon dioxide measurement in the intubated patient, are uniformly applied (711). Specialized monitoring of cardiac and cerebral function varies among centers and includes the use of PACs, TEE, or other forms of echocardiography (Section 2.1.7); noninvasive monitors of cardiac output; processed electroencephalographic monitoring; and cerebral oximetry with near-infrared spectroscopy. Given the added expense and potential hazards of such monitors (e.g., pulmonary artery rupture with PAC, false-positive changes with cerebral oximetry or processed electroencephalogram), substantial controversy exists about indications for their use. None of these monitoring methods is routinely recommended.

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Electrocardiographic monitoring includes an assessment of heart rate and rhythm as well as the morphology and deviation of the QRS complex and ST segments for evidence of ischemia, infarction, or abnormal conduction (690). Continuous telemetric monitoring of cardiac rate and rhythm is recommended for 48 to 72 hours after surgery in all patients because of the high incidence of post-CABG AF, which most often occurs 2 and 4 days after surgery (606,613,690,691,697,698). In addition, other arrhythmias and conduction abnormalities may occur in patients with ischemia because of incomplete revascularization or in those undergoing concurrent valve replacement.

Uncertainty continues with regard to the utility of PAC in low-risk patients undergoing CABG (712). Several observational studies suggest that such patients can be managed only with monitoring of central venous pressure, with insertion of a PAC held in reserve should the need arise. In fact, it has even been suggested that patients in whom a PAC is placed incur greater resource utilization and more aggressive therapy, which may lead to worse outcomes and higher costs. The reported rates of PAC use range from <10% in a combined private–academic setting to >90% in patients in the Department of Veterans Affairs health system (61,639,701,702,713).

Aside from providing an indirect assessment of left atrial pressure and the presence and severity of pulmonary hypertension, PAC can be used to measure cardiac output (by thermodilution) and to monitor the mixed venous oxygen saturation—information that may be helpful in the management of high-risk patients (712,714). The need for careful consideration of baseline patient risk, the planned procedure, and the patient setting before use of a PAC are outlined in several opinion pieces, consensus documents, the "Practice Guidelines for Pulmonary Artery Catheterization: An Updated Report by the American Society of Anesthesiologists", and the "2009 ACCF/AHA Focused Update on Perioperative Beta Blockade Incorporated Into the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery" (699,712,714–716). Pulmonary artery perforation or rupture is fatal in >50% of patients in whom it occurs. This complication usually can be avoided by 1) withdrawal of the catheter tip into the main pulmonary artery before initiation of CPB; 2) withdrawal of the catheter into the pulmonary artery before balloon inflation, especially if the pressure tracing suggests damping; and 3) avoiding routine measurement of the pulmonary artery wedge pressure, reserving this maneuver as a specific diagnostic event.

Perioperative monitoring of cerebral function (primarily with an electroencephalogram) has been used in certain high-risk patients, such as those undergoing neurosurgery or carotid vascular surgery (717). In the setting of cardiac surgery, the potentially deleterious effects of CPB on cerebral hypopfusion or embolic events (i.e., air or aortic calcific debris) have been investigated via transcranial Doppler techniques, with a lesser emphasis on the electroencephalogram (in part because of excessive artifact in this setting) (57,718). Although processed electroencephalographic monitors and bifrontal cerebral oximetry have been available for more than 2 decades, controversy remains about their clinical effectiveness (719,720). Processed electroencephalographic monitoring is aimed primarily at assessing the risk of conscious recall of intraoperative events, but it also has been used to gauge the depth of anesthesia, theoretically allowing more precise titration of the anesthetic (721,722). Although a variety of electroencephalographic variables are commonly accepted as markers of cerebral ischemia, the ability of current commercial devices to detect or quantify ischemia is limited (706,707,717,718).

Given the intuitive link between reflectance oximetry (i.e., for peripheral oxygen or mixed venous oxygen saturation) and clinical interventions (i.e., manipulating hemodynamic variables, the fraction of inspired oxygen, etc.), there is considerable interest in the use of bifrontal cerebral oximetry as a measure of brain perfusion (723). Two RCTs in CABG patients suggest that bifrontal cerebral oximetry may be helpful in predicting early perioperative cognitive decline, stroke, noncerebral complications, and ICU and hospital length of stay (709,710). A 2011 observational cohort (1,178 CABG patients) suggested that a patient's preoperative response to breathing oxygen for 2 minutes (Sco_2 ≤50%) is an independent predictor of death at 30 days and 1 year after surgery (724).

5. CABG-Associated Morbidity and Mortality: Occurrence and Prevention

Several comprehensive data registries for CABG have been developed in the United States, the largest being the STS Adult Cardiac Database. For >20 years, these registries have collected data on all aspects of the procedure (306,725,727). A detailed analysis of these data and their correlation to outcomes has facilitated the creation of risk-assessment models that estimate the rates at which various adverse events occur. On the basis of these models, risk-adjusted outcomes for hospitals and surgeons have been calculated and, in some instances, publicly reported.

5.1. Public Reporting of Cardiac Surgery Outcomes: Recommendation

CLASS I

1. Public reporting of cardiac surgery outcomes should use risk-adjusted results based on clinical data (728–735). *(Level of Evidence: B)*

See Online Data Supplement 31 for additional data on public reporting of cardiac surgery outcomes.

To address the need for valid and reliable risk-adjusted outcomes data, cardiac surgery registries were developed by the STS (306,725,727), Veterans Administration (306,736–738), Northern New England Cardiovascular Disease

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Study Group (739,740), and the state of New York (741,742). These have been the basis for several performance assessment and improvement strategies, including public report cards (742–744), confidential feedback to participants showing their performance relative to national benchmarks (306,737,745–748), and state or regional collaboratives that identify and disseminate best-practices information (749). Public report cards are the most controversial of these 3 approaches. Although they provide transparency and public accountability, it is unclear if they are the only or best way to improve quality. Reductions in the CABG mortality rate after the publication of such report cards in New York were encouraging (742,750–752), but subsequent studies revealed comparable reductions in other states, regions, and countries that used confidential feedback with or without performance improvement initiatives (752–754). These findings suggest that the common denominator among successful performance improvement strategies is the implementation of a formal quality assessment and feedback program benchmarked against regional or national results (755). The incremental value of public (as opposed to confidential) reporting is controversial.

Although providers fear the potential negative impact of public reporting on referrals and market share, this concern seems to be unfounded (756–765). Even when such impact has been observed, it has generally been modest, transient, and limited to areas populated by more affluent and educated subjects (760–762,766). With implementation of healthcare reform legislation that increases access of consumers and payers to objective data and more easily understood data presentations, the influence of public report cards is likely to increase in the future (762,767–771). As this occurs, it will be important to monitor unintended negative consequences, such as "gaming" of the reporting system (772) and avoidance of high-risk patients (risk aversion), the precise group of patients who are most likely to benefit from aggressive intervention (773–776).

Methodological considerations are important for provider profiling and public reporting. Numerous studies have shown the superiority of clinical over administrative data for these purposes (728–731,733,734). The latter data lack critical clinical variables that are necessary for adequate risk adjustment (732,735), they may confuse comorbidities and complications, and they may contain inaccurate case numbers and mortality rates. Outcomes measures, such as mortality, should always be adjusted for patient severity on admission (i.e., "risk-adjusted" or "risk-standardized") (777–780); otherwise, providers will be hesitant to care for severely ill patients, who are more likely to die from their disease. In addition, if a hospital or surgeon is found to be a low-performing outlier on the basis of unadjusted results, the hospital or surgeon may claim that their patients were sicker. Statistical methodologies should account for small sample sizes and clustered patient observations within institutions, and hierarchical or random-effects models have been advocated by some investigators (743,781–787). Point estimates of outcomes should always be accompanied by measures of statistical uncertainty, such as CIs. The units of analysis and reporting for provider profiling also have implications. Surgeon-level reports are published together with hospital reports in several states, but their smaller sample sizes typically require data aggregation over several years. Surgeon-level reporting may also increase the potential for risk aversion, as the anticipated worse results of the highest-risk patients are not diluted by the larger volume of a hospital or group. Finally, because the distribution of patient severity may vary substantially among providers, direct comparison of the results of one surgeon or hospital with those of another, even by using indirectly risk-standardized results, is often inappropriate (788). Rather, these results should be interpreted as comparisons of a provider's outcomes for his or her specific patient cohort versus what would have been expected had those patients been cared for by an "average" provider in the benchmark population.

Although risk-adjusted mortality rate has been the dominant performance metric in cardiac surgery for 2 decades, other more comprehensive approaches have been advocated (789). The STS CABG composite illustrates one such multidimensional approach, consisting of 11 National Quality Forum–endorsed measures of cardiothoracic surgery performance grouped within 4 domains of care (619,790).

5.1.1. Use of Outcomes or Volume as CABG Quality Measures: Recommendations

CLASS I

1. All cardiac surgery programs should participate in a state, regional, or national clinical data registry and should receive periodic reports of their risk-adjusted outcomes. *(Level of Evidence: C)*

CLASS IIa

1. When credible risk-adjusted outcomes data are not available, volume can be useful as a structural metric of CABG quality (309,751,791–798,800–804,807,818). *(Level of Evidence: B)*

CLASS IIb

1. Affiliation with a high-volume tertiary center might be considered by cardiac surgery programs that perform fewer than 125 CABG procedures annually. *(Level of Evidence: C)*

See Online Data Supplement 32 for additional data on outcomes or volume as CABG quality measures.

Numerous studies have demonstrated an association between hospital or individual practitioner volume and outcome for a variety of surgical procedures and some medical conditions (805–831). CABG was one of the original procedures for which this volume–outcome association was investigated (309,751,791–798,800–804,807,818). The CABG volume–outcome association is generally weaker than that of other procedures, such as esophagectomy or pancreatectomy, which are performed less often. In addition, the results of volume–outcome studies vary substantially according to methodology. The apparent strength of

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the volume–outcome association often diminishes with proper risk adjustment based on clinical (as opposed to administrative) data (802,808). It is also weaker in more contemporary studies, presumably because of improved techniques and increasing experience (795,802). Finally, volume–outcome associations appear weaker when hierarchical models are used that properly account for small sample sizes and clustering of observations (832). The impact of CABG volume was studied in an observational cohort of 144,526 patients from 733 hospitals that participated in the STS Adult Cardiac Surgery Database in 2007 (309). In this analysis, a weak association between volume and unadjusted mortality rate was noted (2.6% unadjusted mortality rate for hospitals performing <100 procedures versus 1.7% for hospitals performing ≥450 procedures) (309). Using multivariate hierarchical regression, the largest OR (1.49) was found for the lowest-volume (<100 cases) group versus the highest-volume group. Desirable processes of care (except for use of the IMA) and morbidity rates were not associated with volume. The average STS-CABG composite score for the lowest-volume group (<100 cases per year) was significantly lower than that of the 2 highest-volume groups, but volume explained only 1% of variation in the composite score (619,790).

In general, the best results are achieved most consistently by high-volume surgeons in high-volume hospitals and the worst results by low-volume surgeons in low-volume hospitals (793,794). However, many low-volume programs achieve excellent results, perhaps related to appropriate case selection; effective teamwork among surgeons, nurses, anesthesiologists, perfusionists, and physician assistants; and adoption of best practices derived from larger programs (833,834).

As a quality assessment strategy, participation in a state, regional, or national clinical data registry that provides regular performance feedback reports is highly recommended for all cardiac programs. Random sampling variation is greater at low volumes (309,797,798,803,827,834,835), which complicates performance assessment of smaller programs. Several strategies may be considered to mitigate this measurement issue, including analysis over longer periods of time; appropriate statistical methodologies, such as hierarchical (random-effects) models; composite measures, which effectively increase the number of endpoints; and statistical quality control approaches, such as funnel plots (835) and cumulative sum plots (836–838). Small programs may benefit from direct supervision by a large tertiary center (834). Ultimately, state or national regulatory authorities must decide whether the lower average performance of very small programs and the added difficulty in accurately measuring their performance are outweighed by other considerations, such as the need to maintain cardiac surgery capabilities in rural areas with limited access to referral centers (834).

Volume, a structural quality metric, is an imperfect proxy for direct measurement of outcomes (822,839). Risk-adjusted outcomes based on clinical data are the preferred method of assessing CABG quality except in very low-volume programs, in which performance is generally weakest and small sample size makes accurate assessment of performance difficult.

5.2. Adverse Events

5.2.1. Adverse Cerebral Outcomes

5.2.1.1. STROKE

The incidence of stroke after CABG ranges from 1.4% to 3.8% (840), depending on the patient population and the criteria for diagnosis of stroke. Risk factors for stroke include advanced age, history of stroke, diabetes mellitus, hypertension (841), and female sex (842), with newer research emphasizing the importance of preoperative atherosclerotic disease (including radiographic evidence of previous stroke or aortic atheromatous disease) (843). Although macroembolization and microembolization are major sources of stroke, hypoperfusion (844), perhaps in conjunction with embolization (845), is a risk factor for postoperative stroke. The mortality rate is 10-fold higher among post-CABG patients with stroke than among those without it, and lengths of stay are longer in stroke patients (846).

Although off-pump CABG was introduced in large part to reduce stroke and other adverse neurological outcomes associated with CPB, several RCTs comparing on-pump and off-pump CABG have shown no difference in stroke rates (61,68,78,846a,846b,1069,1259).

See Online Data Supplement 33 for additional data on stroke rates.

5.2.1.1.1. USE OF EPIAORTIC ULTRASOUND IMAGING TO REDUCE STROKE RATES: RECOMMENDATION

CLASS IIa

1. **Routine epiaortic ultrasound scanning is reasonable to evaluate the presence, location, and severity of plaque in the ascending aorta to reduce the incidence of atheroembolic complications (847–849). (*Level of Evidence: B*)**

Identification of an atherosclerotic aorta is believed to be an important step in reducing the risk of stroke after CABG (850). Intraoperative assessment of the ascending aorta for detection of plaque by epiaortic ultrasound imaging is superior to direct palpation and TEE (851,852). Predictors of ascending aortic atherosclerosis include increasing age, hypertension, extracardiac atherosclerosis (peripheral artery and cerebrovascular disease), and elevated serum creatinine concentrations (853–855). Prospective RCTs to evaluate the role of epiaortic scanning in assessing stroke risk have not been reported, but several observational studies reported stroke rates of 0 to 1.4% (847–849,853,856,857) when surgical decision making was guided by the results of epiaortic scanning. Separate guidelines for the use of intraoperative epiaortic ultrasound imaging in cardiac surgery

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were endorsed and published in 2008 by the American Society for Echocardiography, Society of Cardiovascular Anesthesiologists, and STS (147).

5.2.1.1.2. THE ROLE OF PREOPERATIVE CAROTID ARTERY NONINVASIVE SCREENING IN CABG PATIENTS: RECOMMENDATIONS

CLASS I

1. A multidisciplinary team approach (consisting of a cardiologist, cardiac surgeon, vascular surgeon, and neurologist) is recommended for patients with clinically significant carotid artery disease for whom CABG is planned. *(Level of Evidence: C)*

CLASS IIa

1. Carotid artery duplex scanning is reasonable in selected patients who are considered to have high-risk features (i.e., age >65 years, left main coronary stenosis, PAD, history of cerebrovascular disease [transient ischemic attack [TIA], stroke, etc.], hypertension, smoking, and diabetes mellitus) (858,859). *(Level of Evidence: C)*
2. In the CABG patient with a previous TIA or stroke and a significant (50% to 99%) carotid artery stenosis, it is reasonable to consider carotid revascularization in conjunction with CABG. In such an individual, the sequence and timing (simultaneous or staged) of carotid intervention and CABG should be determined by the patient's relative magnitudes of cerebral and myocardial dysfunction. *(Level of Evidence: C)*

CLASS IIb

1. In the patient scheduled to undergo CABG who has no history of TIA or stroke, carotid revascularization may be considered in the presence of bilateral severe (70% to 99%) carotid stenoses or a unilateral severe carotid stenosis with a contralateral occlusion. *(Level of Evidence: C)*

Because the presence of extracranial disease of the internal carotid artery is a risk factor for adverse neurological events after CABG (860), one might argue for use of carotid noninvasive scanning (duplex ultrasonography or noninvasive carotid screening) in all patients scheduled for CABG. At issue is the effectiveness of noninvasive carotid screening in identifying carotid artery stenoses of hemodynamic significance. Alternatively, the identification of preoperative risk factors known to be associated with the presence of carotid artery disease could be used to stratify patients into high- and low-risk categories, thereby allowing for a more selective use of noninvasive carotid screening. A retrospective analysis of 1,421 consecutive CABG patients identified the following as risk factors for significant carotid artery disease: age >65 years, presence of a carotid bruit, and a history of cerebrovascular disease (858). In so doing, they reduced preoperative testing by 40%, with only a "negligible" impact on surgical management or neurological outcomes. Similarly, the following risk factors have been identified as predicting the presence of >50% reduction in internal diameter of the internal carotid artery: smoking, diabetes mellitus, hypertension, a previous cerebrovascular event, PAD, left main CAD, and a history of cervical carotid disease (859). All subjects found to have significant carotid disease were noted to have ≥1 of these criteria. In addition, the probability of detecting significant carotid disease increased almost 3 times for each additional criterion that was present. The authors noted that the presence of a single preoperative risk factor increased the sensitivity of the screening test to 100% and increased the specificity to 30%. As a result, they strongly recommend a selective approach to the use of preoperative noninvasive carotid screening, allowing for a decrease in the number of unnecessary tests but exerting little effect on the detection of significant carotid disease.

In patients undergoing carotid endarterectomy, the rates of periprocedural stroke have been reported to be as high as 2.5% in those with asymptomatic carotid stenoses (861) and 5% in those with previous cerebrovascular symptoms (862). In CABG patients with >50% unilateral carotid stenoses in whom carotid endarterectomy is not performed concomitantly with CABG, the peri-CABG stroke rate is reportedly 3%, rising to 5% in those with bilateral carotid artery stenoses and 11% in those with an occluded carotid artery (860). In light of these data, the issue of combined carotid and coronary revascularization (performed simultaneously or in a staged, sequential fashion) as a strategy to reduce the postoperative stroke risk in CABG patients with known carotid artery disease has received substantial attention. The lack of clarity about the optimal approach to the management of such patients is the result of several factors:

- To date, no published randomized, prospective study has addressed this important clinical scenario (863).
- The etiology of postoperative stroke often is multifactorial (e.g., ascending aortic calcifications with resultant atherothrombotic embolization, preexisting carotid artery disease, air or debris cerebral embolization associated with CPB, episodes of transient intraoperative hypotension).
- Many risk factors for stroke coexist in CABG patients.
- The rates for postoperative stroke and death for carotid endarterectomy and for CABG, independent of or in conjunction with one another, vary considerably in different patient populations (e.g., young versus old, male versus female, etc.).
- More than half of all post-CABG strokes occur after uneventful recovery from CABG and are believed to be caused by supraventricular arrhythmias, low cardiac output, or postoperative hypercoagulability (863).
- A substantial proportion of post-CABG strokes occur in patients without significant carotid artery disease or in an anatomic distribution not consistent with a known significant carotid arterial stenosis.

Advances in technologies for carotid and coronary revascularization make the decision-making process for the procedures even more complex. In addition to conventional CABG with CPB, the surgeon may choose an off-pump technique in certain patients (e.g., those with a heavily calcified ascending aorta). Likewise, carotid artery stenting provides an alternative to endarterectomy, which may re-

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duce the risk of postoperative stroke. Still, the ultimate impact of such stenting on postoperative stroke rates in CABG patients awaits the results of properly designed trials. At present, carotid artery stenting is reserved for CABG patients in whom a contraindication to open endarterectomy exists.

When combined carotid and coronary revascularization is indicated, an awareness of the stroke and mortality rates for different patient subgroups will help to guide decision making. Several factors favor combined revascularization, including (but not limited to) 1) severe carotid artery disease, 2) unfavorable morphological characteristics of the carotid lesion(s) (e.g., ulcerated lesions), 3) the presence of related symptoms, and 4) a history of TIA or stroke. In those with a history of TIA or stroke who have a significant carotid artery stenosis (50% to 99% in men or 70% to 99% in women), the likelihood of a post-CABG stroke is high; as a result, they are likely to benefit from carotid revascularization (863). Conversely, CABG alone can be performed safely in patients with asymptomatic unilateral carotid stenoses, because a carotid revascularization procedure offers no discernible reduction in the incidence of stroke or death in these individuals. Men with asymptomatic bilateral severe carotid stenoses (50% to 99%) or a unilateral severe stenosis in conjunction with a contralateral carotid artery occlusion may be considered for carotid revascularization in conjunction with CABG. Little evidence exists to suggest that women with asymptomatic carotid artery disease benefit from carotid revascularization in conjunction with CABG (864). Whether the carotid and coronary revascularization procedures are performed simultaneously or in a staged, sequential fashion is usually dictated by the presence or absence of certain clinical variables. In general, synchronous combined procedures are performed only in those with both cerebrovascular symptoms and ACS.

The optimal management of patients with coexisting carotid artery disease and CAD is poorly defined. Several therapeutic approaches can be used, including staged carotid endarterectomy and CABG, simultaneous carotid endarterectomy and CABG, or similar variations that use endovascular stenting as the primary carotid intervention. At present, no prospective RCTs comparing neurological outcomes after these different treatment strategies in patients with coexisting carotid artery disease and CAD have been reported (865).

5.2.1.2. DELIRIUM

The incidence of postoperative delirium after CABG is <10%, similar to that reported after noncardiac surgery (866–868). The risk factors for postoperative delirium are similar for cardiac and noncardiac surgery and include advanced age, preexisting cognitive impairment, and vascular disease (866,868,869). The burden of intraoperative cerebral microemboli does not predict the presence or severity of postoperative delirium (870). The development of postoperative delirium has been linked to functional decline at 1 month, short-term cognitive decline (871), and risk of late mortality (867,872).

5.2.1.3. POSTOPERATIVE COGNITIVE IMPAIRMENT

Short-term cognitive changes occur in some patients after on-pump CABG (873–875). The precise incidence depends on the timing of the postoperative assessment and the choice of criteria for cognitive decline (876,877). Similar short-term cognitive changes also are noted in elderly patients receiving general anesthesia for noncardiac surgery (878–880). Risk factors for short-term postoperative cognitive decline include preexisting risk factors for cerebrovascular disease (881), preexisting central nervous system disease (882), and preexisting cognitive impairment (75). Up to 30% of candidates for CABG have been shown to have cognitive impairment before surgery (75). A few studies have reported a lower incidence of short-term cognitive decline after off-pump CABG than on-pump CABG (883), but most studies have shown no difference in cognitive outcomes between them (884). Studies with appropriate comparison groups have demonstrated that most patients do not suffer cognitive decline after CABG (885,886). For those who do, the postoperative cognitive changes are generally mild, and for most patients, they resolve within 3 months of surgery (887).

Long-term cognitive decline after CABG has been reported (888,889), but other studies have shown that a similar degree of late cognitive decline occurs in comparison groups of demographically similar patients with CAD but without surgery, suggesting that the late decline is not related to the use of CPB (890). An RCT comparing late cognitive outcomes after on-pump and off-pump CABG has reported no difference between them (891).

See Online Data Supplement 34 for additional data on the role of perioperative cognitive impairment.

5.2.2. Mediastinitis/Perioperative Infection: Recommendations

CLASS I

1. Preoperative antibiotics should be administered to all patients to reduce the risk of postoperative infection (892–897). *(Level of Evidence: A)*
2. A second-generation cephalosporin is recommended for prophylaxis in patients without methicillin-resistant *Staphylococcus aureus* colonization (897–905). *(Level of Evidence: A)*
3. Vancomycin alone or in combination with other antibiotics to achieve broader coverage is recommended for prophylaxis in patients with proven or suspected methicillin-resistant *S. aureus* colonization (900,906–908). *(Level of Evidence: B)*
4. A deep sternal wound infection should be treated with aggressive surgical debridement in the absence of complicating circumstances. Primary or secondary closure with muscle or omental flap is recommended (909–911). Vacuum therapy in conjunction with early and aggressive debridement is an effective adjunctive therapy (912–921). *(Level of Evidence: B)*

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5. Use of a continuous intravenous insulin protocol to achieve and maintain an early postoperative blood glucose concentration less than or equal to 180 mg/dL while avoiding hypoglycemia is indicated to reduce the risk of deep sternal wound infection (583,586,590,591,922,923). *(Level of Evidence: B)*

CLASS IIa

1. When blood transfusions are needed, leukocyte-filtered blood can be useful to reduce the rate of overall perioperative infection and in-hospital death (924–927). *(Level of Evidence: B)*
2. The use of intranasal mupirocin is reasonable in nasal carriers of *S. aureus* (928,929). *(Level of Evidence: A)*
3. The routine use of intranasal mupirocin is reasonable in patients who are not carriers of *S. aureus,* unless an allergy exists. *(Level of Evidence: C)*

CLASS IIb

1. The use of bilateral IMAs in patients with diabetes mellitus is associated with an increased risk of deep sternal wound infection, but it may be reasonable when the overall benefit to the patient outweighs this increased risk. *(Level of Evidence: C)*

See Online Data Supplements 35 and 36 for additional data on mediastinitis and perioperative infection.

Nosocomial infections occur in 10% to 20% of cardiac surgery patients. To prevent surgical site infections in CABG patients, a multimodality approach involving several perioperative interventions must be considered. Preoperative interventions include screening and decolonization of patients with methicillin-resistant and methicillin-sensitive *S. aureus* colonization and adequate preoperative preparation of the patient. Nasal carriage of *S. aureus* is a well-defined risk factor for subsequent infection. In proven nasal carriers of *S. aureus,* intranasal mupirocin reduces the rate of nosocomial *S. aureus* infection, but it does not reduce the rate of surgical site infection with *S. aureus* (928,929). Preoperative patient bathing, the use of topical antiseptic skin cleansers (chlorhexidine gluconate) (930–932), and proper hair removal techniques (using electric clippers or depilatories rather than razors) (933–937) are important measures with which to prepare the patient for surgery.

Intraoperative techniques to decrease infection include strict adherence to sterile technique, minimization of operating room traffic, less use of flash sterilization of surgical instruments, minimization of electrocautery (933,936) and bone wax (938), use of double-gloving (938–943), and shorter operative times. Identification of patients at high risk for preoperative infection allows the clinician to maximize prevention strategies. Superficial wound infection occurs in 2% to 6% of patients after cardiac surgery (656,944–946), and deep sternal wound infection occurs in 0.45% to 5%, with a mortality rate of 10% and 47% (947–953).

The etiology of deep sternal wound infection is multifactorial. Risk factors for deep sternal wound infection are diabetes mellitus (25,27,28), obesity (body mass index >30 kg/m^2) (947,949,950,953,954), chronic obstructive pulmonary disease (950), prolonged CPB time, reoperation, prolonged intubation time, and surgical reexploration (945,947,955). Potentially modifiable risk factors are smoking cessation, optimized nutritional status, adequate preoperative glycemic status (with hemoglobin A1c <6.9%), and weight loss. The use of bilateral IMAs has been a subject of investigation as a risk factor for deep sternal wound infection. Each IMA provides sternal branches, which provide 90% of the blood supply to each hemi-sternum. As a result, IMA harvesting can compromise sternal wound healing. Although no RCTs assessing the risk of deep sternal wound infection after bilateral IMA grafting have been reported, the use of bilateral IMAs in patients with diabetes and those with other risk factors for surgical site infection increases the incidence of deep sternal wound infection (956,957). Skeletonization of the IMA may be associated with a beneficial reduction in the incidence of sternal wound complications, more evident in patients with diabetes mellitus (958).

Transfusion of homologous blood is a risk factor for adverse outcomes after cardiac surgery. Blood transfusions after CABG are correlated in a dose-related fashion to an increased risk of transfusion-related infection, postoperative infection, postoperative morbidity, and early and late death (959–962). In addition, they have been associated with a higher incidence of sternal wound infections (949,963,964). In a retrospective analysis of 15,592 cardiovascular patients, the risk of septicemia/bacteremia and superficial and deep sternal wound infections increased incrementally with each unit of blood transfused (961). The leukocytes that are present in packed red blood cells induce the immunomodulatory effects associated with blood transfusions. Allogenic transfusions of blood containing leukocytes induce higher concentrations of proinflammatory mediators (such as interleukins 6 and 10) than does the transfusion of leukocyte-depleted blood (924–927,965). In patients undergoing cardiac surgery, RCTs have shown that those receiving leukocyte-filtered blood have lower rates of perioperative infection and in-hospital death than those receiving non–leukocyte-filtered blood (924–927). An RCT showed that those receiving leukocyte-depleted blood had a reduced rate of infection (17.9% versus 23.5%; p=0.04) and 60-day mortality (transfused/nonfiltered patient mortality rate, 7.8%; transfused/filtered at the time of donation, 3.6%; and transfused/filtered at the time of transfusion, 3.3% [p=0.019]) (927). Leukodepletion can be accomplished by the blood bank at the time of donation or at the bedside at the time of transfusion (with the use of an inexpensive in-line transfusion filter). Preoperative antibiotics reduce the risk of postoperative infection 5-fold (892). Interest has grown in administering antibiotic prophylaxis as a single dose rather than as a multiple-dosing regimen for 24 to 48 hours, because single-dose antibiotic prophylaxis reduces the duration of prophylaxis, its cost, and the likelihood of antimicrobial resistance.

Staphylococcus coagulase–negative epidermidis or *S. aureus* (including methicillin-resistant *S. aureus*) account for 50% of surgical site infections. Other organisms that are often

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involved are *Corynebacterium* and enteric gram-negative bacilli (966–968). Antibiotic prophylaxis against these organisms should be initiated 30 to 60 minutes before surgery, usually at the time of anesthetic induction, except for vancomycin, which should be started 2 hours before surgery and infused slowly to avoid the release of histamine (903,969,970). In patients without methicillin-resistant *S. aureus* colonization, a cephalosporin (cefazolin, 1 g given intravenously every 6 hours, or cefuroxime, 1.5 g given intravenously every 12 hours) is the agent of choice for standard CABG (897–905). Antibiotic redosing is performed if the operation lasts >3 hours (970). Vancomycin is reserved for the patient who is allergic to cephalosporins or has known or presumed methicillin-resistant *S. aureus* colonization (900,906–908).

The incidence of deep sternal wound infection has decreased over the past 15 years despite an increased risk profile of patients undergoing cardiac surgery (i.e., increased comorbidities, obesity, diabetes mellitus, and advanced age) (971). Several options are available for the treatment of deep sternal wound infection. The main treatment is surgical debridement with primary or delayed reconstruction with vascularized soft tissue (pectoral muscle or omentum) (909–912,972). Conventional treatment with pectoralis flap muscle or omentum is associated with procedure-related morbidities, such as destabilization of the thoracic cage, surgical trauma, and potential failure of the flap. In current practice, the vacuum-assisted closure system is often used in the treatment of mediastinitis (913). With it, local negative pressure is applied to the open wound, accelerating granulation tissue formation and increasing blood supply. Such vacuum-assisted closure therapy, which is less invasive than conventional surgical treatment, has been used as standalone therapy, as a bridge to flap advancement, or as sternal preconditioning and preservation followed by titanium plate sternal osteosynthesis (913,914,973). Although several studies have suggested that vacuum-assisted closure therapy can be a successful alternative to conventional standard therapy (913–921,973), the data are from single-center retrospective studies of patients with heterogeneous disease processes. As a result, it seems reasonable to suggest that both conventional and vacuum-assisted closure therapy can be used in the treatment of mediastinitis.

5.2.3. Renal Dysfunction: Recommendations

CLASS IIb

1. In patients with preoperative renal dysfunction (creatinine clearance <60 mL/min), off-pump CABG may be reasonable to reduce the risk of acute kidney injury (AKI) (974–978). *(Level of Evidence: B)*
2. In patients with preexisting renal dysfunction undergoing on-pump CABG, maintenance of a perioperative hematocrit greater than 19% and mean arterial pressure greater than 60 mm Hg may be reasonable. *(Level of Evidence: C)*
3. In patients with preexisting renal dysfunction, a delay of surgery after coronary angiography may be reasonable until the effect of radiographic contrast material on renal function is assessed (979–981). *(Level of Evidence: B)*
4. The effectiveness of pharmacological agents to provide renal protection during cardiac surgery is uncertain (982–1004). *(Level of Evidence: B)*

See Online Data Supplements 37 to 39 for additional data on CABG and renal dysfunction.

Depending on the definition used, the incidence of AKI (defined in various studies as an increase in serum creatinine concentration and/or decrease in calculated glomerular filtration rate of a certain magnitude) after isolated CABG is 2% to 3%, and the incidence of AKI requiring dialysis is 1% (1005). Risks factors for developing AKI after CABG are preoperative renal dysfunction, LV systolic dysfunction, PAD, advanced age, race, female sex, type of surgery, diabetes mellitus requiring insulin, emergency surgery, preoperative intraaortic balloon support, and congestive heart failure or shock (1005–1013).

The pathogenesis of postoperative AKI is usually multifactorial. The identification and effective management of modifiable variables can minimize its occurrence. CPB can lead to renal dysfunction if renal perfusion is not adequately maintained. In addition, CPB leads to a systemic inflammatory response, with the release of 1) inflammatory cytokines (e.g., kallikrein, bradykinin), 2) catecholamines, and 3) other hormones (e.g., renin, aldosterone, angiotensin II, vasopressin), all of which influence renal function. The effects of hypothermia during CPB on renal function are uncertain. Two RCTs (1014,1015) showed no effect of CPB temperature on renal function in patients undergoing CABG, whereas a 2010 observational study (1016) of 1,072 subjects identified a relationship between a CPB temperature <27°C and the development of AKI (OR: 1.66; 95% CI: 1.16 to 2.39; p=0.005). Although off-pump CABG may theoretically avoid CPB-related renal injury, the cardiac manipulation that is often required to obtain adequate exposure may cause transient decreases in cardiac output, increased peripheral vasoconstriction, and decreased renal perfusion (1017). A meta-analysis of 6 RCTs and 16 observational studies (encompassing data from 27,806 patients) suggested a modest beneficial effect of off-pump CABG in reducing the incidence of AKI but no advantage in reducing the incidence of AKI–dialysis (977). These findings were confirmed by another published RCT of 2,203 patients, in which the incidence of AKI–dialysis was similar among those undergoing off-pump and on-pump CABG (0.8% for off pump; 0.9% for on pump; p=0.82) (61). Considering the low (approximately 1%) incidence of AKI–dialysis in subjects undergoing CABG, available RCTs are underpowered to detect a difference in outcome. In patients with renal dysfunction preoperatively, it might be reasonable to perform off-pump CABG to reduce the risk of AKI (974–976,978,996). During CPB, hemodilution is induced to reduce blood viscosity and plasma oncotic

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pressure to improve regional blood flow in the setting of hypothermia and hypoperfusion. However, an excessively low hematocrit on CPB is associated with increased adverse events and in-hospital deaths (1018). In patients undergoing isolated CABG, it has been reported that the mortality rate of patients with a single hematocrit value <19% was twice that of those with a hematocrit of 25% (1019). On the basis of these data, a hematocrit <19% on CPB should be avoided.

No drugs have been identified that prevent or alleviate CABG-associated AKI. N-acetylcysteine reduces proinflammatory cytokine release, oxygen free radical generation, and reperfusion injury, but a review of 10 RCTs containing data from 1,163 patients (982) showed that it did not reduce the incidence of AKI and AKI–dialysis (987). In several RCTs, atrial natriuretic peptide was shown to reduce peak postoperative serum creatinine concentrations, increase urine output, and reduce the need for dialysis in individuals with normal renal function preoperatively, but it did not prevent AKI–dialysis in patients with preexisting renal dysfunction (996).

Fenoldopam, a selective dopamine D_1 receptor agonist that causes vasodilatation and increases renal cortical and outer medullary blood flow, seems to exert protective renal effects in critically ill patients (994,995). A meta-analysis of the data from 1,059 patients reported in 13 randomized and case-matched studies showed that fenoldopam exerts a beneficial effect on renal function. Compared with standard therapy, fenoldopam reduced the need for renal replacement therapy (5.7% versus 13.4%; OR: 0.37; 95% CI: 0.23 to 0.59; $p<0.001$) and lowered the peak value for serum creatinine concentration. Nevertheless, this beneficial effect was counterbalanced by an increased rate of hypotension and vasopressor requirements (15% versus 10.2%; OR: 1.94; 95% CI: 1.1.9 to 3.16; $p=0.008$). Dopamine at low doses increases renal blood flow and blocks the tubular reabsorption of sodium. A meta-analysis on the use of low-dose dopamine reported that it increased urine output and improved serum creatinine concentrations without influencing the need for renal replacement therapy or the rates of adverse events or death (990).

Diltiazem and mannitol have been used to prevent AKI after cardiac surgery (988). Diltiazem may inhibit the inflammatory response that occurs with CPB (992), whereas mannitol produces an osmotic diuresis (1000). The role of mannitol in preventing AKI is unclear (983,1004). Diltiazem does not prevent renal dysfunction (983). Contrast-induced nephropathy is a common cause of AKI. It is usually self-limited and manifests its peak effect 3 to 5 days after the administration of contrast material. In patients with preoperative renal dysfunction, it is reasonable to delay surgery for several days after coronary angiography to reduce the incidence of AKI (979–981).

5.2.4. Perioperative Myocardial Dysfunction: Recommendations

CLASS IIa

1. **In the absence of severe, symptomatic aorto-iliac occlusive disease or PAD, the insertion of an intraaortic balloon is reasonable to reduce mortality rate in CABG patients who are considered to be at high risk (e.g., those who are undergoing reoperation or have LVEF <30% or left main CAD) (1021–1026). *(Level of Evidence: B)***
2. **Measurement of biomarkers of myonecrosis (e.g., creatine kinase-MB, troponin) is reasonable in the first 24 hours after CABG (200). *(Level of Evidence: B)***

Intraaortic balloon counterpulsation is an established mechanical cardiac support procedure that has been demonstrated to increase cardiac output and to improve coronary blood flow (1025,1026). In several RCTs, its preoperative initiation and perioperative use have been shown to reduce the mortality rate in CABG patients who are considered to be at high risk (i.e., those undergoing repeat CABG, those with an LVEF <30%, or those with left main CAD) (1022–1024) despite its known associated vascular complications (1021). In contrast, its routine use in subjects who are not thought to be high risk has not been demonstrated (1027).

Some myocyte necrosis often occurs during and immediately after CABG, caused by cardiac manipulation, inadequate myocardial protection, intraoperative defibrillation, or acute graft failure. A determination of the frequency and magnitude with which postoperative myonecrosis occurs has been difficult. In 2007, the European Society of Cardiology/ACCF/AHA/World Heart Federation Task Force for the Redefinition of Myocardial Infarction stated, "[B]iomarker values more than 5 times the 99th percentile of the normal reference range during the first 72 h following CABG, when associated with the appearance of new pathological Q-waves or new [left bundle branch block], or angiographically documented new graft or native coronary artery occlusion, or imaging evidence of new loss of viable myocardium should be considered as diagnostic of a CABG-related myocardial infarction (type 5 myocardial infarction)" (203, p. 2183). Until 2000, the conventional biomarker for myonecrosis was creatine kinase-MB, but at present cardiac-specific troponin is the preferred indicator of myonecrosis (198,200). The higher the serum concentrations of biomarkers after CABG, the greater the amount of myonecrosis and, therefore, the greater the likelihood of an adverse outcome.

Published data from the PREVENT IV trial suggest, first, that serum biomarkers for myonecrosis are elevated postoperatively even in roughly 10% of CABG subjects who are considered to be low risk for the procedure and, second, that short-term (30-day) and long-term (2-year) outcomes were worse in these patients than in those without a postoperative biomarker elevation. Similarly, a direct correlation has been noted between the presence and magnitude

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of biomarker elevations postoperatively and both intermediate- and long-term risk of death (1028).

5.2.4.1. TRANSFUSION: RECOMMENDATION

CLASS I

1. **Aggressive attempts at blood conservation are indicated to limit hemodilutional anemia and the need for intraoperative and perioperative allogeneic red blood cell transfusion in CABG patients (1029–1032). *(Level of Evidence: B)***

Numerous large observational studies have identified perioperative allogeneic red blood cell transfusion(s) as an independent risk factor for adverse outcomes, including death (1029–1032). A prospective observational study of 8,004 patients demonstrated that the transfusion of allogeneic red blood cells in CABG patients was associated with an increased risk of low-output heart failure irrespective of the extent of hemodilutional anemia (1030). An adverse outcome may be caused by immunomodulation (known to occur with red blood cell transfusion), initiation of a systemic inflammatory response and its associated direct negative myocardial effects, reduced red blood cell capacity for adequate oxygen delivery (1031,1032) (diphosphoglycerate function in "banked" blood may cause tissue hypoxia), and changes in red blood cell morphology of transfused blood. Regardless of etiology, myocardial depression is observed consistently after allogeneic red blood cell transfusion, and this effect appears to be dose dependent. Even risk-adjusted survival rates after CABG in patients transfused with allogeneic red blood cells are reduced (1029–1032).

5.2.5. Perioperative Dysrhythmias: Recommendations

CLASS I

1. **Beta blockers should be administered for at least 24 hours before CABG to all patients without contraindications to reduce the incidence or clinical sequelae of postoperative AF (604–608,608a–608c). *(Level of Evidence: B)***
2. **Beta blockers should be reinstituted as soon as possible after CABG in all patients without contraindications to reduce the incidence or clinical sequelae of AF (604–608,608a–608c). *(Level of Evidence: B)***

CLASS IIa

1. **Preoperative administration of amiodarone to reduce the incidence of postoperative AF is reasonable for patients at high risk for postoperative AF who have contraindications to beta blockers (1036). *(Level of Evidence: B)***
2. **Digoxin and nondihydropyridine calcium channel blockers can be useful to control the ventricular rate in the setting of AF but are not indicated for prophylaxis (606,1037–1041). *(Level of Evidence: B)***

AF immediately after CABG, occurring in 20% to 50% of patients, is often difficult to manage and is associated with a substantially increased risk of morbidity (particularly disabling embolic events) and mortality. A prospective observational study of 1,878 consecutive subjects undergoing CABG noted that post-CABG AF was associated with a 4-fold increased risk of disabling embolic stroke and a 3-fold increased risk of cardiac-related death (607).

The incidence of postoperative AF is increased in the presence of advanced patient age, male sex, PAD, chronic lung disease, concomitant valvular heart disease, left atrial enlargement, previous cardiac surgery, preoperative atrial tachyarrhythmias, pericarditis, and elevated postoperative adrenergic tone. However, many subjects have none of these factors, yet they develop AF in the immediate postoperative period. Postoperative AF almost always occurs within 5 days postoperatively, with a peak incidence on the second postoperative day (608). Numerous trials have assessed the efficacy of various pharmacologic agents in preventing post-CABG AF, including beta-adrenergic-blockers, various antiarrhythmic agents, glucocorticosteroids, hormonal agents (e.g., triiodothyronine), and even statins. Preoperative and postoperative beta blockers (or possibly amiodarone) are most effective at reducing its incidence, with several RCTs showing that they effectively accomplish this goal. In contrast, glucocorticosteroids, hormonal agents, and statins are not effective at decreasing its occurrence (604–606,608b,608c,1042). In subjects without pre-CABG AF, post-CABG AF usually resolves spontaneously within 6 weeks of surgery. As a result, the preferred management strategy of post-CABG AF in such patients often consists of control of the ventricular rate (with beta blockers) in anticipation of spontaneous reversion to sinus rhythm within a few weeks. In addition, if the patient is considered to be at risk for a thromboembolic event while in AF, anticoagulation (with heparin and then warfarin) is warranted. For a more detailed description of the management of subjects with postoperative AF, the reader is referred to the 2011 ACCF/AHA/HRS guidelines for the Management of Patients with Atrial Fibrillation (608).

5.2.6. Perioperative Bleeding/Transfusion: Recommendations

CLASS I

1. **Lysine analogues are useful intraoperatively and postoperatively in patients undergoing on-pump CABG to reduce perioperative blood loss and transfusion requirements (1044–1051). *(Level of Evidence: A)***
2. **A multimodal approach with transfusion algorithms, point-of-care testing, and a focused blood conservation strategy should be used to limit the number of transfusions (1052–1057). *(Level of Evidence: A)***
3. **In patients taking thienopyridines (clopidogrel or prasugrel) or ticagrelor in whom elective CABG is planned, clopidogrel and ticagrelor should be withheld for at least 5 days (520,521,523,524, 531,1058–1063) *(Level of Evidence: B)* and prasugrel for at least 7 days (533) *(Level of Evidence: C)* before surgery.**
4. **It is recommended that surgery be delayed after the administration of streptokinase, urokinase, and tissue-type plasminogen activators until hemostatic capacity is restored, if possible. The timing of recommended delay should be guided by the pharmacodynamic half-life of the involved agent. *(Level of Evidence: C)***
5. **Tirofiban or eptifibatide should be discontinued at least 2 to 4 hours before CABG and abciximab at least 12 hours before CABG (526–528,1049,1050,1064–1068). *(Level of Evidence: B)***

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CLASS IIa

1. It is reasonable to consider off-pump CABG to reduce perioperative bleeding and allogeneic blood transfusion (67,1069–1074). *(Level of Evidence: A)*

See Online Data Supplements 40 to 42 for additional data on bleeding/transfusion.

Approximately 10% of allogeneic blood transfusions in the United States are given to subjects undergoing cardiac surgery (1075). Allogeneic transfusion carries the risks of transfusion reactions, air-borne infections, and increased hospital costs. In patients undergoing isolated CABG, transfusions are associated with reduced long-term survival and worse quality of life (1029,1076).

About 10% to 20% of the cardiac patients who are transfused receive roughly 80% of the transfusions that are administered (1075,1078). These high-risk patients often can be identified preoperatively to facilitate measures directed at blood conservation. Several reports have identified risk factors for blood transfusions (1079–1082), including advanced age, preoperative anemia, small body size, reoperative CABG, priority of operation, duration of CPB, presence of preoperative coagulopathy, and preoperative antithrombotic therapy (1080,1083–1088). A multimodal approach that includes transfusion algorithms, point-of-care testing, and a focused blood conservation strategy can limit the percentage of patients requiring transfusion and the amount of blood transfusions per patient (1052–1057).

About 60% to 70% of CABG patients are taking aspirin at the time of the procedure (536,1089,1090). Although aspirin increases perioperative blood loss and blood transfusion requirements (1091–1098), the amount of blood loss can be minimized by avoiding CPB (1099) and by using blood conservation techniques. In a meta-analysis of data from 805 patients (1100), doses of preoperative aspirin >325 mg were associated with increased bleeding (mean difference, 230 mL), whereas those who received <325 mg preoperatively did not have a significant increase in blood loss (mean difference: 65.3 mL; 95% CI: 20.2 to 150.8; p=0.134).

Some subjects undergoing CABG are receiving DAPT. Multiple studies have shown that the preoperative use of aspirin and clopidogrel is associated with increased perioperative bleeding, transfusions, and required reexploration for bleeding (522–524,531,1058–1062,1101–1107). In a study of 350 CABG patients at 14 centers, the risk of reexploration for bleeding was increased 3-fold in patients who were exposed to clopidogrel within 5 days of surgery; half of these patients required transfusions (520). In patients taking clopidogrel in whom elective CABG is planned, the drug should be withheld for 5 to 7 days before surgery. In subjects taking DAPT because of previous placement of a DES, clopidogrel can be stopped 1 year after the most recent DES placement. If CABG cannot be postponed, some operators have suggested that the patient be hospitalized for conversion of thienopyridine therapy to short-acting glycoprotein IIb/IIIa inhibitors for several days before surgery (497,1063,1108,1109); however, no data are available demonstrating the efficacy of such a management strategy. Streptokinase, urokinase, and tissue-type plasminogen activator should be stopped before CABG; in these individuals, the timing of CABG depends on the pharmacodynamic half-life of the agent involved (1110).

The use of unfractionated heparin has not been associated with increased perioperative blood loss; it can be continued until a few hours before CABG. Low-molecular-weight heparin can be administered safely ≤12 hours preoperatively and does not result in excessive perioperative blood loss (1064–1068). Lysine analogues, such as epsilon-aminocaproic acid and tranexamic acid, inhibit fibrinolysis by binding to the plasminogen molecule. Several trials have shown that both epsilon-aminocaproic acid and tranexamic acid reduce blood loss and blood transfusions during cardiac surgery, but they do not reduce the rate of reexploration for bleeding (1044–1051). Both drugs appear to be safe and do not increase the risk of death (1111).

Erythropoietin is a glycoprotein hormone that stimulates red blood cell production. Recombinant human erythropoietin is used in combination with iron supplementation to treat anemic patients (hemoglobin levels <13 g/dL) with renal failure and those undergoing chemotherapy. The use of erythropoietin in cardiac surgery has been studied in 12 RCTs and has been shown to be associated with significant risk reduction in allogeneic blood transfusion after cardiac surgery (1112–1122). However, the data from the RCTs are heterogeneous, with different doses of erythropoietin administered for 1 to 3 weeks preoperatively; as a result, further studies are needed to define more precisely the patient subgroups who may benefit from this therapy (1123). In patients who refuse blood transfusions during cardiac surgery, a short-term course of preoperative erythropoietin, to produce a high hematocrit preoperatively, may be administered (1124,1125). Alternatively, autologous blood donation may be used, which consists of extracting 1 to 3 units during the 30 days preoperatively and then reinfusing it during or postoperatively. However, such a practice is uncommon because of the increased risk of hemodynamic instability.

Off-pump CABG may avoid CPB-related coagulopathy caused by exposure of blood to artificial surfaces, mechanical trauma, alterations in temperature, and hemodilution. Some evidence suggests that off-pump CABG is associated with less bleeding and fewer blood transfusions (67,1069–1074).

6. Specific Patient Subsets

6.1. Elderly

The term "elderly" in CABG patients is usually defined as ≥80 years of age. Compared with younger subjects, the elderly are more likely to have severe (left main or multivessel) CAD, LV systolic dysfunction, concomitant valvular

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disease, and previous sternotomy. In addition, they often have comorbid conditions, such as diabetes mellitus, hypertension, chronic obstructive pulmonary disease, PAD, and azotemia. As a result, the elderly have a higher perioperative risk of morbidity and mortality than do younger patients receiving CABG. The operative mortality rate among the elderly ranges from 2.6% (in a population >75 years of age) to 11% (in a population >80 years of age undergoing urgent or emergency surgery) (298,1126). Retrospective studies have observed a substantially higher in-hospital mortality rate among octogenarians than among younger patients (1127–1130). A report from the National Cardiovascular Network of outcomes in 67,764 patients undergoing cardiac surgery, of whom 4,743 were octogenarians, showed that the in-hospital mortality rate for the octogenarians was substantially higher (3.0% versus 8.1%; $p<0.001$) (1127).

Several retrospective studies of patients undergoing CABG have reported a higher incidence of neurological complications, renal failure, respiratory failure, and gastrointestinal complications among octogenarians than among younger subjects (298,1127,1128). In addition, the elderly have longer lengths of stay and are less likely to be discharged home. An analysis of the New York State Department of Health Cardiac Reporting System registry revealed that length of stay after CABG was 8.5 days in patients <50 years of age and 14.1 days in those >80 years of age, with discharge-to-home rates of 96% and 52%, respectively (1126).

Despite higher rates of in-hospital morbidity and mortality, the majority of octogenarians achieve functional improvement after CABG. Two studies of patients ≥80 years of age demonstrated improvements in quality of life, as assessed by the Seattle Angina Questionnaire (1131,1132). In 1 of these, angina relief and quality-of-life improvement scores after CABG did not differ between patients >75 and ≤75 years of age (1126). Of 136 octogenarians who underwent CABG, 81% felt that they were left with little or no disability in their daily activities, and 93% reported substantial symptomatic improvement an average of 2.1 years postoperatively (1131).

6.2. Women

Data on the influence of sex on CABG outcomes are limited. The BARI (Bypass Angioplasty Revascularization Investigation) study compared the outcomes of 1,829 patients with multivessel CAD randomly assigned to receive CABG or PCI; 27% were women (1133). Most information on the efficacy of CABG comes from studies done primarily in men, with extrapolation of the results to women. Although long-term outcomes with CABG in women are similar to or even better than those in men, women have higher rates of periprocedural morbidity and mortality (1133–1139). Several hypotheses have been suggested to explain this increased morbidity and mortality, including older age at presentation, more frequent need for urgent revascularization, more comorbid conditions, smaller body surface area and coronary arterial dimensions, and increased risk of bleeding. The fact that women on average are older than men at the time of CABG is thought, at least in part, to be due to the loss of the protective effects of estrogen with menopause (1134,1138,1140–1148). In studies of age-matched men and women undergoing CABG, in-hospital mortality rates were similar, even among the elderly (≥70 years of age) (1149,1150).

In addition to being older, women undergoing CABG are more likely than men to have ACS and cardiogenic shock (1140) and, therefore, to require urgent revascularization (1138,1141–1143,1146,1148). Sex disparity in the diagnosis and treatment of CAD may contribute to the more complex and delayed presentations in women compared with men (1151). In comparison to men, women are less likely to be referred for coronary angiography and revascularization and are more likely to have refractory ischemia and repeated hospitalizations (1152).

Compared with men undergoing CABG, women have more comorbid conditions, including diabetes mellitus, hypertension, hyperlipidemia, chronic renal insufficiency, chronic obstructive pulmonary disease, and concomitant valvular disease (1153). In some studies, no significant difference in outcomes between women and men undergoing CABG was noted when the data were adjusted for age and comorbidities (1136–1138,1154–1156), whereas in others, female sex remained an independent predictor of a worse outcome (1141,1157,1158). In a systematic review of sex differences and mortality after CABG, early mortality differences were reduced but not eliminated after adjustment for comorbidities, procedural characteristics, and body habitus (1139). Some investigators have shown that smaller body surface area, a surrogate for coronary arterial size, is associated with higher risk of perioperative mortality, whereas others have not (1140).

Women use more hospital resources in the perioperative period than do men, including intra-aortic balloon counterpulsation (1137), vasopressors, mechanical ventilation, dialysis, and blood products (1154,1159), all of which are associated with higher mortality rates (1146,1160,1161). Women are more likely to have wound complications and longer ICU and hospital stays (1162–1165). Lastly, the operative procedure itself appears to be different in women than in men, in that women are less likely to be completely revascularized (1166,1167) and less likely to have IMA grafting, especially bilateral (1168), even though bilateral IMA grafting in women is associated with low rates of in-hospital morbidity and mortality (1169).

6.3. Patients With Diabetes Mellitus

The prevalence of diabetes mellitus in CABG patients has increased markedly over the past 30 years. In the late 1970s, only 10% to 15% of CABG patients had diabetes (1170); by 2005, the incidence had risen to 35% (308). Patients with diabetes, especially those who are insulin dependent, have higher rates of perioperative morbidity and mortality and a

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reduced long-term survival rate than those without diabetes (308,1171,1172). In the STS Registry, patients with diabetes on oral therapy had an adjusted OR of 1.15 for death within 30 days of CABG (95% CI: 1.09 to 1.21) as well as a greater likelihood of stroke, renal failure, and deep sternal wound infection than those without diabetes (308). For subjects receiving insulin, the adjusted OR for death within 30 days was 1.50 (95% CI: 1.42 to 1.58), and the risks for other complications were correspondingly higher. The poorer short-term outcome in patients with diabetes is only partly explained by a greater frequency of other comorbid conditions, such as obesity, hypertension, renal insufficiency, PAD, and cerebrovascular disease. The reduced long-term survival rate after CABG in patients with diabetes is likely due to a combination of more rapid progression of atherosclerosis, a lower long-term patency rate of SVGs (1173), and a greater burden of comorbid conditions. As in patients without diabetes, long-term outcome after CABG is better when an IMA is used as a conduit than when CABG is performed with only SVGs (362).

A subgroup analysis of data from the BARI trial suggested that patients with diabetes who underwent CABG with 1 arterial conduit had improved survival compared with those who underwent PCI (516). Several subsequent observational and cohort studies also showed that CABG results in better long-term outcome in patients with diabetes and multivessel CAD compared with balloon angioplasty or BMS implantation (361,451,1174). A meta-analysis of 10 RCTs comparing CABG with balloon angioplasty (n=6) or BMS implantation (n=4) concluded that the mortality rate was substantially lower in patients with diabetes undergoing CABG (451).

Little information is available about CABG versus PCI with DES in patients with diabetes mellitus. The results of CARDia (Coronary Artery Revascularisation in Diabetes), the first RCT comparing CABG and PCI in a population consisting entirely of subjects with diabetes, suggested that PCI with DES (used in 69% of the PCI patients) and CABG achieved similar outcomes (475). Of the 1,800 subjects enrolled in the SYNTAX trial, which compared CABG and PCI with paclitaxel-eluting stents, 452 had medically treated diabetes (364). At 1-year follow-up, the 2 treatments exerted a similar effect on survival, MI, and the composite endpoint of death, MI, or stroke. As in the entire SYNTAX cohort, patients with diabetes randomly assigned to receive PCI had a higher rate of repeat revascularization (20.3% after PCI versus 6.4% after CABG; $p<0.001$), and those with highly complex lesions (i.e., SYNTAX score $\geq$33) had a higher mortality rate with PCI (13.5% versus 4.1%; $p=0.04$). The FREEDOM (Future Revascularization Evaluation in patients with Diabetes mellitus: Optimal management of Multivessel disease) trial, an ongoing randomized comparison of CABG and PCI with DES in 1,900 patients with diabetes and multivessel CAD, should shed further light on the preferred therapy for these patients (1175).

Few comparisons of CABG and contemporary medical therapy in patients with diabetes mellitus are of sufficient size to allow meaningful conclusions. The largest such trial, BARI 2D, randomly assigned 2,368 patients with type 2 diabetes mellitus to revascularization plus intensive medical therapy or intensive medical therapy alone (404,1176), with patients in the medical therapy group to undergo revascularization during follow-up only if such therapy were clinically indicated by the progression of angina or the development of an ACS or severe ischemia. The planned method of revascularization, PCI or CABG, was determined before randomization by the treating physicians. No significant difference in primary endpoints was evident between the PCI group and the medical therapy group. No difference in survival rate between those undergoing CABG and those receiving only medical therapy was noted. Acute MI occurred less often in those assigned to CABG plus intensive medical therapy than in those given intensive medical therapy alone (10% versus 17.6%; $p=0.003$), and the composite endpoints of death or MI (21.1% versus 29.2%; $p=0.01$) and cardiac death or MI also occurred less often (1176). Compared to those selected for PCI, the CABG patients had more 3-vessel CAD (52% versus 20%), more totally occluded arteries (61% versus 32%), more proximal LAD artery stenoses >50% (19% versus 10%), and a higher myocardial jeopardy score.

Elevated fasting blood glucose concentrations before CABG and persistently elevated glucose concentrations afterward are associated with increased risk of morbidity and mortality (592,1177,1178). The complications most closely linked to postoperative hyperglycemia are infections, including deep sternal wound infection and mediastinitis. Achieving glycemic control perioperatively in patients with diabetes decreases this risk (581,593). Because the risk of deep sternal wound infection in patients with diabetes is increased when both IMAs are harvested and used, bilateral IMA grafting is not recommended in this patient cohort unless the overall benefit to the patient outweighs this increased risk (957).

6.4. Anomalous Coronary Arteries: Recommendations

CLASS I

1. Coronary revascularization should be performed in patients with:
   a. A left main coronary artery that arises anomalously and then courses between the aorta and pulmonary artery (1179–1181). *(Level of Evidence: B)*
   b. A right coronary artery that arises anomalously and then courses between the aorta and pulmonary artery with evidence of myocardial ischemia (1179–1182). *(Level of Evidence: B)*

CLASS IIb

1. Coronary revascularization may be reasonable in patients with a LAD coronary artery that arises anomalously and then courses between the aorta and pulmonary artery. *(Level of Evidence: C)*

Several variations and anatomic courses of anomalous coronary arteries have been described, some benign and others

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associated with sudden cardiac death. The most life-threatening variants involve anomalous origin of the left main coronary artery from the right sinus of Valsalva or of the right coronary artery from the left sinus of Valsalva, after which the anomalous artery travels to its normal area of perfusion between the ascending aorta and the main pulmonary artery. In a review of consecutive echocardiograms in 2,388 asymptomatic children and young adolescents, the incidence of anomalous coronary arteries arising from the opposite sinus of Valsalva was 0.17% (1183). Anomalous coronary arteries (particularly those traversing between the aorta and the main pulmonary artery) are associated with exercise-related sudden death in young (≤35 years of age) athletes (1184–1190). A consecutive series of 27 young athletes with sudden death who were found to have such anomalous coronary arteries at autopsy had inducible myocardial ischemia and complained of cardiac symptoms before their demise (1179). Isolated case reports of other coronary arterial anomalies in subjects with syncope or sudden death emphasize the need for careful anatomic and functional evaluation of all individuals with anomalous coronary arteries (1191–1194). The method of revascularization employed in adults with anomalous coronary arteries has been 1) CABG or, more recently, 2) PCI with stenting (1195). When CABG is employed, consideration should be given to the presence of competitive flow in the native coronary circulation (1196). In children and some adults, an unroofing procedure or coronary arterial reimplantation may provide the best long term results (1197,1198). The risk associated with these coronary anomalies if they are left untreated and the existing operative experience make corrective surgery reasonable in these individuals (1180).

6.5. Patients With Chronic Obstructive Pulmonary Disease/Respiratory Insufficiency: Recommendations

CLASS IIa

1. Preoperative intensive inspiratory muscle training is reasonable to reduce the incidence of pulmonary complications in patients at high risk for respiratory complications after CABG (1199). *(Level of Evidence: B)*

CLASS IIb

1. After CABG, noninvasive positive pressure ventilation may be reasonable to improve pulmonary mechanics and to reduce the need for reintubation (1200,1201). *(Level of Evidence: B)*
2. High thoracic epidural analgesia may be considered to improve lung function after CABG (37,1202). *(Level of Evidence: B)*

See Online Data Supplement 43 for additional data on patients with chronic obstructive pulmonary disease/respiratory insufficiency.

In the STS Adult Cardiac Database predictive algorithms, the presence of chronic obstructive pulmonary disease preoperatively was an independent predictor of mortality, the need for prolonged postoperative ventilator support, and renal failure (1203). Furthermore, most rehospitalizations following CABG are related to pulmonary dysfunction and/or infection or volume overload. The incidence of complications increases with patient age and the severity of chronic obstructive pulmonary disease, as measured with pulmonary function testing (1204,1205). None of these studies, however, address the relative risks and benefits of CABG in subjects with chronic obstructive pulmonary disease, thereby precluding a specific recommendation regarding the performance of CABG in these patients. In preparation for CABG, optimizing pulmonary function is imperative (1206). An RCT of 279 patients (1199) showed that preoperative respiratory muscle training reduced postoperative pulmonary complications (including pneumonia) and length of stay in patients at high risk for such complications after CABG. Such muscle training is indicated in all patients before CABG, especially those with impaired baseline pulmonary function.

Two prospective RCTs have shown that prophylactic nasal continuous positive airway pressure after CABG improves pulmonary function and offers protection from postoperative pulmonary complications (1200,1201). However, the applicability of these results to patients with impaired pulmonary function is uncertain, because those with severe underlying lung disease and other comorbid conditions were not enrolled. Although noninvasive positive pressure ventilation may be useful in subjects with borderline pulmonary function postoperatively, its overuse should be avoided, because it may cause gastric distention, thereby increasing the risk of vomiting and aspiration. Improved lung function has been achieved with the use of high thoracic epidural anesthesia in patients undergoing CABG (36,37), but its application has been limited by concerns about paraspinal and epidural hemorrhage related to epidural catheter insertion.

Despite some evidence that oral corticosteroids improve pulmonary function after cardiac surgery (1207,1208), their use has not been adopted widely in subjects undergoing CABG. Finally, a consistent reduction in postoperative pulmonary complications has not been shown when off-pump (as opposed to on-pump) CABG is performed (1209).

6.6. Patients With End-Stage Renal Disease on Dialysis: Recommendations

CLASS IIb

1. CABG to improve survival rate may be reasonable in patients with end-stage renal disease undergoing CABG for left main coronary artery stenosis of greater than or equal to 50% (479). *(Level of Evidence: C)*
2. CABG to improve survival rate or to relieve angina despite GDMT may be reasonable for patients with end-stage renal disease with significant stenoses (≥70%) in 3 major vessels or in the proximal LAD artery plus 1 other major vessel, regardless of LV systolic function (1210). *(Level of Evidence: B)*

CLASS III: HARM

1. CABG should not be performed in patients with end-stage renal disease whose life expectancy is limited by noncardiac issues. *(Level of Evidence: C)*

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Rates of cardiovascular morbidity and mortality are increased in patients with CKD compared with age-matched controls without CKD, and the magnitude of the increase is directly related to the severity of CKD. About half of those on maintenance dialysis die from a cardiovascular cause (476). At present, the prevalence of CKD in the general population of the United States is estimated to be 13%, with approximately 5.8% of these having Stage III–V disease (i.e., glomerular filtration rate <60 mL/min/1.73 m^2) (1211). In 2009, >525,000 Americans were receiving maintenance hemodialysis (1212).

To date, randomized comparisons of CABG and medical therapy in patients with CKD (irrespective of its severity) have not been reported. Observational studies have demonstrated an improved survival rate with CABG (compared with medical therapy) in patients with CKD and multivessel CAD (57,479). At the same time, these observational studies as well as other registries have demonstrated a markedly reduced long-term survival rate in patients with CKD undergoing CABG compared with nondialysis CABG patients (1213–1216), with the magnitude of the decrease directly related to the severity of CKD. In these reports, subjects with CKD undergoing CABG had an increased incidence of periprocedural complications, including mediastinitis, need for blood transfusion, prolonged ventilation, reoperation, stroke, and increased length of hospital stay (1210).

6.7. Patients With Concomitant Valvular Disease: Recommendations

CLASS I

1. Patients undergoing CABG who have at least moderate aortic stenosis should have concomitant aortic valve replacement (1217–1220). *(Level of Evidence: B)*
2. Patients undergoing CABG who have severe ischemic mitral valve regurgitation not likely to resolve with revascularization should have concomitant mitral valve repair or replacement at the time of CABG (1221–1226). *(Level of Evidence: B)*

CLASS IIa

1. In patients undergoing CABG who have moderate ischemic mitral valve regurgitation not likely to resolve with revascularization, concomitant mitral valve repair or replacement at the time of CABG is reasonable (1221–1226). *(Level of Evidence: B)*

CLASS IIb

1. Patients undergoing CABG who have mild aortic stenosis may be considered for concomitant aortic valve replacement when evidence (e.g., moderate–severe leaflet calcification) suggests that progression of the aortic stenosis may be rapid and the risk of the combined procedure is acceptable. *(Level of Evidence: C)*

6.8. Patients With Previous Cardiac Surgery: Recommendation

CLASS IIa

1. In patients with a patent LIMA to the LAD artery and ischemia in the distribution of the right or left circumflex coronary arteries, it is reasonable to recommend reoperative CABG to treat angina if GDMT has failed and the coronary stenoses are not amenable to PCI (380,1227). *(Level of Evidence: B)*

6.8.1. Indications for Repeat CABG

RCTs comparing medical therapy to CABG in subjects with SIHD demonstrated that those with specific angiographic findings, such as left main disease, 3-vessel disease, and 2-vessel disease that includes the proximal LAD artery, derive a survival benefit from CABG (318). At the same time, it is unknown if CABG provides a survival benefit compared with medical therapy in patients with these anatomic findings who have had previous CABG. It is logical to assume that subjects with previous CABG and these anatomic findings would, in fact, derive a survival benefit from repeat CABG provided that CABG could be performed with an acceptable risk. The importance of recurrent MI in the distribution of the LAD artery has been shown to be associated with a poor prognosis in patients with previous CABG. The long-term outcomes of 723 patients with diseased SVGs who did not undergo reoperation or PCI within 1 year of angiography were reviewed (1228). A stenosis of a graft to the LAD artery was associated with decreased rates of survival, reoperation-free survival, and event-free survival. On the basis of these data, these authors suggest that a >50% stenosis in a graft to the LAD artery is an indication for reoperation. In contrast, patients without ischemia in the LAD artery distribution do not derive a survival benefit from repeat CABG. In an observational study from the Cleveland Clinic, the survival rate of 4,640 patients with patent LIMA grafts to the LAD artery and ischemia in the distribution of the right and/or left circumflex arteries who were treated with repeat CABG, PCI, or medical therapy was examined (380). No improvement in survival was observed in either revascularization group compared with those treated medically.

6.8.2. Operative Risk

Because of the technical difficulty of repeat CABG and the high risk profiles of these patients, reoperative CABG is associated with higher rates of morbidity and mortality than is primary CABG (945,1229–1235). With advances in surgical techniques, some groups have reported a decline in mortality rate for patients undergoing repeat CABG (1233,1236). An observational study suggested that the higher operative risk with reoperation is related to the higher patient risk profiles and not to the technical challenges of the operation itself, thereby suggesting that improvements in surgical techniques have neutralized the risk associated with the complexity of repeat CABG (1233), but others continue to suggest that technical issues are still important in causing the higher mortality rate in these individuals.

6.8.3. Long-Term Outcomes

The survival rate after repeat CABG is lower than that after primary CABG. A multicenter study from Australia re-

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ported 1, 3, 5, and 6 year survival rates in reoperative CABG patients of 93.1%, 90.5%, 85.9%, and 80.5%, respectively (1235)—survival results that were significantly lower than those observed after primary CABG. However, after adjusting for differences in risk profiles between primary and reoperative CABG patients, no difference in long-term survival rate was apparent. The variables associated with decreased late survival rate included advanced age, hypertension, elevated serum cholesterol, diabetes mellitus, PAD, renal failure, left main CAD, LV systolic dysfunction, and emergency status (1235).

Compared with primary CABG, repeat CABG is less successful at relieving angina (1237,1238), although a 2004 quality-of-life analysis reported that repeat CABG was as effective as primary CABG in relieving angina and improving functional capacity and quality of life (1239).

6.9. Patients With Previous Stroke

Patients with a previous stroke or TIA are at higher risk for a perioperative stroke during CABG than those without such a history. A meta-analysis of the data from several studies observed a perioperative stroke risk of 8.5% in patients with previous stroke (compared with 2.2% in those without a previous neurological event) ($p<0.0001$) (860). When subjects with a history of stroke or TIA were analyzed separately (i.e., stroke only or TIA only), the increased perioperative risk in comparison with neurologically asymptomatic patients was present in both groups. In a multivariate logistic regression analysis of 16,194 cardiac surgery patients, a history of cerebrovascular disease was identified as an independent predictor of perioperative stroke (1240). The STS National Cardiac Surgery Database demonstrated an increased risk of perioperative death, perioperative stroke, and prolonged length of stay in patients with a history of stroke who underwent isolated CABG from 2002 to 2006 (308).

6.10. Patients With PAD

CAD and PAD, generally defined as atherosclerotic disease of the aorta, its visceral arterial branches (renal and mesenteric), and the arteries of the lower extremities, often coexist. The presence of PAD is an independent predictor of early (1241) and late death in CABG patients. In the STS National Cardiac Surgery Database, 774,881 patients underwent isolated CABG over a 5-year period, of whom 15.5% had PAD. The presence of PAD was an independent risk factor for in-hospital death or death within 30 days of CABG. In addition, PAD was an independent risk factor for perioperative stroke and subsequent need for post-CABG limb revascularization or amputation. Potential but unproven explanations for the adverse effects of PAD on long-term survival after CABG include: 1) The presence of PAD may lead to vascular events (i.e., cerebrovascular events) that adversely affect post-CABG survival; 2) PAD may be a marker for more severe CAD, which may lead to an increased rate of post-CABG death from cardiac causes despite revascularization; and 3) PAD may contribute to noncardiovascular death in the long term. Revascularization of PAD before CABG is not known to improve post-CABG outcomes.

7. Economic Issues

7.1. Cost-Effectiveness of CABG and PCI

In the United States, it is estimated that the annual hospital costs of CABG are approximately $10 billion (1242). Despite the increasing risk profile of CABG candidates, it nonetheless is becoming more cost-effective. Hospital charges from the Nationwide Inpatient Sample of nearly 5.5 million patients who had isolated CABG in the United States from 1988 to 2005 were examined (1243). A decrease in risk-adjusted mortality rate, from 6.2% to 2.1% ($p<0.0001$), was noted. When hospital costs were corrected for inflation, they declined from $26,210 in 1988 to $19,196 in 2005 ($1,988) ($p<0.0001$).

Several factors tend to increase the cost of CABG, including advanced patient age, female sex, African-American ethnicity, postoperative complications, longer hospital stay, and multiple comorbidities, particularly CKD (1244–1247). The National Health Service Foundation Trust in Britain found that patients >75 years of age undergoing CABG had higher rates of postoperative complications and greater resource utilization than their younger counterparts (1244). Similarly, the Maryland Health Services Cost Review Commission reported an increased total cost and length of hospital stay with increasing age in patients undergoing CABG (1245). The same phenomenon was not present with PCI until the patients were >80 years old. In an examination of data from 12,016 subjects undergoing CABG in New York State in 2003, it was determined that older age, female sex, and African-American ethnicity were associated with higher costs (1247). Clinical characteristics, such as a lower LVEF, number of diseased vessels, previous open-heart operations, and numerous comorbidities, further increased costs. Larger hospitals were associated with higher CABG discharge costs, whereas costs significantly decreased with higher CABG volumes.

Not surprisingly, perioperative complications lead to increased costs. An examination of the Medicare Provider Analysis and Review file of data from 114,223 Medicare beneficiaries who survived CABG in 2005 showed the mean cost of hospitalization associated with CABG to be $32,201 ± $23,059 for a mean length of stay of 9.9 ± 7.8 days. Those with complications (13.6% of patients) consumed significantly more hospital resources (incremental cost, $15,468) and had a longer length of stay (average additional stay, 1.3 days) (1246).

Evidence for the role of off-pump versus on-pump CABG in decreasing costs is conflicting. In a randomized study comparing off-pump and on-pump CABG, the mean total hospitalization cost per patient was $2,272 less for

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off-pump CABG at hospital discharge and $1,955 less at 1 year (1248). Another study of 6,665 patients who underwent CABG between 1999 and 2005 determined that off-pump CABG provided a small short-term gain (1249), although off-pump patients had increased long-term risks of repeat revascularization and major vascular events, especially if they were considered to be high risk. In the long run, in fact, off-pump patients utilized more resources.

7.1.1. Cost-Effectiveness of CABG Versus PCI

Medical costs and quality of life were examined 10 to 12 years after patients were randomly assigned to receive angioplasty or CABG in the BARI trial (1250). Although CABG costs initially were 53% higher, the gap closed to <5% by the end of 2 years. After 12 years, the average cost was $123,000 in CABG patients and $120,000 for PCI patients. Cumulative costs were significantly higher among patients with diabetes mellitus, heart failure, and comorbid conditions, and they were higher in women. CABG was deemed to be as cost-effective as PCI in patients with multivessel CAD.

The cost of coronary artery revascularization in 6,218 patients with and without CKD whose data were available in the Duke database was examined (1251). CABG was an economically attractive alternative to PCI or medical therapy for all patients with left main or 3-vessel CAD without concomitant CKD as well as those with 2-vessel CAD with concomitant CKD. For subjects with 3-vessel CAD and concomitant CKD, 2-vessel CAD without CKD, and 1-vessel CAD regardless of renal function, medical therapy was an economically attractive strategy compared with CABG or PCI. This analysis concluded that CABG is most economically attractive compared with PCI and medical therapy in patients to whom it confers the greatest survival advantage and for whom the cost of alternative treatments is greatest (i.e., those with the most severe CAD). Although CABG was more expensive than medical therapy for all patients, the survival benefits associated with it were of such magnitude in some subjects that it was economically attractive.

The cost-effectiveness of CABG and PCI in high-risk patients was analyzed in the AWESOME (Angina With Extremely Serious Operative Mortality Evaluation) study (446), in which costs were assessed at 3 and 5 years. After 3 years, the average total cost was $63,896 for PCI and $84,364 for CABG, a difference of $20,468. After 5 years, the average total cost was $81,790 for PCI and $100,522 for CABG, a difference of $18,732. The authors concluded that PCI was less costly and at least as effective for urgent revascularization in high-risk patients with medically refractory angina.

7.1.2. CABG Versus PCI With DES

The use of DES for PCI will require a reassessment of cost-effectiveness. Although the initial procedure is considerably more expensive than the use of balloon angioplasty or BMS, equaling the cost of CABG in many patients with multivessel CAD, the cost of reintervention for restenosis may be reduced. The cost-effectiveness will depend on the pricing of stents, utilization rates of the more expensive stents, and efficacy. In a 2010 study from Japan comparing the total costs at 2 years of CABG and DES implantation in patients with left main CAD, the total costs were significantly lower for those undergoing CABG than for those receiving a DES (1252).

8. Future Research Directions

With improvements in percutaneous techniques and medical therapy, on-pump CABG and off-pump CABG will increasingly be reserved for patients with extensive CAD, many of whom have had previous PCI. The future of CABG will be directed at improving its results in high-risk patients and making CABG less invasive for elective revascularization. Minimally invasive techniques, with the use of robotics and anastomotic connectors, intraoperative imaging, hybrid procedures, and protein and gene therapy, appear promising. Robotic technology in minimally invasive CABG leads to less traumatic harvesting of the LIMA for minimally invasive direct coronary artery bypass procedures compared with nonrobotic techniques (1253). The ultimate goal of robotic CABG is totally endoscopic CABG, but its use has been limited, at least partly because of a substantial learning curve, cost considerations, and few data demonstrating noninferior graft patency and outcomes compared with standard CABG.

Anastomotic connectors may enable more routine application of totally endoscopic anastomoses in subjects undergoing minimally invasive CABG. Because hand-sewn anastomoses are technically challenging when performed endoscopically, consideration has been given to the concept of anatomic connectors to facilitate more reproducible and less technically demanding procedures and ultimately to allow widespread use. Both proximal and distal connectors may be used. Several options are being developed, some only available outside the United States, and the evidence base supporting their use is evolving (1254). The PAS-Port proximal device has been associated with acceptable outcomes. In two prospective studies, its angiographic graft patency 9 months after CABG was similar to that of hand-sewn anastomoses (1255,1256). With this device, the proximal anastomoses must be constructed before the distal ones. At present, only 1 distal device, the Cardica C-Port, has been approved for use in the United States. The prospective studies (1257,1258) demonstrated a 6-month overall patency of 96% in 102 subjects. These devices increase the cost of the operation.

Over the past 20 years, the patency rate of all graft types has improved gradually, so that the present failure rate of LIMA grafts at 1 year is about 8% and of SVGs roughly 20% (1259). Many patients being referred for CABG nowadays have far advanced CAD, which is often diffuse

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and exhibits poor vessel runoff. Technical issues at the time of surgery may influence graft patency, and intraoperative imaging may help to delineate technical from nontechnical issues. Because coronary angiography is rarely available intraoperatively, other techniques have been developed to assess graft integrity at this time, most often the transit-time flow and intraoperative fluorescence imaging. The transit-time flow is a quantitative volume-flow technique that cannot define the severity of graft stenosis or discriminate between the influence of the graft conduit and the coronary arteriolar bed on the mean graft flow. Intraoperative fluorescence imaging, which is based on the fluorescent properties of indocyanine green, provides a "semiquantitative" assessment of graft patency with images that provide some details about the quality of coronary anastomoses (1260). Although both methods are valuable in assessing graft patency, neither is sufficiently sensitive or specific to allow identification of more subtle abnormalities (1260). It is hoped that such imaging may help to reduce the occurrence of technical errors.

The hybrid suite can be used as an operating room and a catheterization laboratory. It allows the performance of an angiogram after CABG so that one can identify abnormal grafts, providing the opportunity to revise them (with PCI or surgery) before leaving the operating room. Until completion angiography becomes more routine (in a hybrid suite), cardiac surgeons must rely on reasonably accurate, albeit imperfect, methods to identify problems with a recently implanted graft.

8.1. Hybrid CABG/PCI

Advances in surgical techniques and the introduction of DES have provided a platform for a "hybrid revascularization strategy" that combines grafting the LAD artery with the LIMA and stenting the non-LAD arteries with DES (instead of bypassing them with SVGs). Although preliminary data (1261) have indicated that a hybrid strategy may be a reasonable alternative in some patients with multivessel CAD, its real effect will not be known until results of RCTs are available (1261). The primary purpose of performing hybrid CABG is to decrease the morbidity rate of traditional CABG in high-risk patients. Although hybrid revascularization is most often performed in a staged fashion, a simultaneous hybrid procedure can be performed in a hybrid suite, offering several potential advantages, including improving the efficiency and cost-effectiveness of therapy as well as condensing therapy into 1 patient encounter. If a staged approach is chosen, minimally invasive CABG performed first, followed days later by PCI, is probably preferable, so as to enable surgery without the unwanted effects of antiplatelet therapy as well as to enable complete angiography of the LIMA graft at the time of PCI. The major disadvantage of this approach is that if complications occur with PCI, a third procedure may be necessary. Even with a hybrid suite, one of the most substantive barriers to simultaneous minimally invasive CABG and PCI is the management of antiplatelet therapy. The role of hybrid CABG–PCI compared with sole PCI and sole conventional CABG awaits the results of the ongoing observational study of hybrid coronary revascularization by the National Heart, Lung, and Blood Institute.

8.2. Protein and Gene Therapy

Several proteins, such as vascular endothelial growth factor, acidic fibroblast growth factor, and basic fibroblast growth factor, induce angiogenesis (1262); as a result, interest has grown in using these substances to stimulate myocardial perfusion. One RCT found that patients who were given 100 mcg of basic fibroblast growth factor became angina free, and nuclear perfusion testing appeared to show improved perfusion (1262). Another RCT has suggested that the intracoronary injection of high-dose angiogenic molecules yields improvement in symptoms, exercise time, functional capacity, and myocardial perfusion (1263). Alternatively, gene therapy may be used to induce angiogenesis, but conceptual concerns with intravascular gene therapy, such as peripheral uptake into nontarget tissues and subsequent unintended effects, have been raised.

8.3. Teaching CABG to the Next Generation: Use of Surgical Simulators

Over the past decade, pressure on hospitals and physicians to ensure high quality and safety has increased. Public reporting of outcomes, common in many states, has been endorsed by the STS. In addition, healthcare reform has placed great emphasis on the efficiency of care. These factors, coupled with the increased complexity of patients referred for CABG, the decreased number of qualified physicians specializing in cardiac surgery, and the restrictions on resident work hours, make the teaching of surgical techniques to the next generation a substantial challenge.

Given the success of simulator training of airline and military personnel, it has the potential to have a major impact on surgical training paradigms. With surgical simulators, a trainee's first distal anastomosis in an actual patient will occur only after mastering the technique on a simulator (1264). The mastery of basic skills will allow the trainee to focus on more complex tasks as well as to understand the conduct of the operation more thoroughly and quickly. The fundamentals of simulator training are based on the learning principle of "deliberate practice," in which an individual practices a finite task until it is mastered. Still, before this method of training can be incorporated into a formal curriculum, several issues must be addressed. Trainees must have adequate supervision and instruction to ensure appropriate technique, which will require that attending surgeons have time away from clinical and academic duties to provide simulator training. This poses a considerable challenge under current reimbursement requirements, and a reimbursement system that provides an incentive to active surgeons to teach residents in the simulation laboratory will be required. As an alternative,

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training programs may opt to hire recently retired surgeons to teach in the simulation laboratory. Finally, simulators must become more robust, with perhaps computer-enhanced clinical scenarios, before the residents who train on them are qualified to care for patients.

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Key Words: ACCF/AHA Practice Guidelines ■ acute coronary syndromes ■ anticoagulants ■ antiplatelet agents ■ arrhythmias, cardiac ■ coronary angiography ■ coronary artery revascularization interventions: stents ■ drug therapy ■ heart diseases ■ myocardial revasularization ■ platelet aggregation inhibitor ■ ultrasound.

APPENDIX 1. AUTHOR RELATIONSHIPS WITH INDUSTRY AND OTHER ENTITIES (RELEVANT)—2011 ACCF/AHA GUIDELINE FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Committee Member	Employer/Title	Consultant	Speaker's Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, Organizational, or Other Financial Benefit	Expert Witness	Voting Recusals by Section Numbers*
L. David Hillis *(Chair)*	University of Texas Health Science Center at San Antonio—Professor and Chair of the Department of Medicine	None	None	None	None	None	None	None
Peter K. Smith *(Vice Chair)*	Duke University Medical Center: Private Diagnostic Clinic—Professor of Surgery; Chief of Thoracic Surgery	• Eli Lilly • Baxter BioSurgery	None	None	None	None	None	2.2.3 4.1 4.2 5.2.6
Jeffrey L. Anderson	Intermountain Medical Center—Associate Chief of Cardiology	• BMS/sanofi-aventis	None	None	• AstraZeneca • Gilead Pharma • Toshiba†	None	None	2.1.6 2.2.3 4.1 4.2 4.3 5.2.6

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Committee Member	Employer/Title	Consultant	Speaker's Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, Organizational, or Other Financial Benefit	Expert Witness	Voting Recusals by Section Numbers*
John A. Bittl	Ocala Heart Institute Munroe Regional Medical Center—Interventional Cardiologist	None	None	None	None	None	None	None
Charles R. Bridges	University of Pennsylvania Medical Center—Chief of Cardiothoracic Surgery	• Baxter BioSurgery† • Zymogenetics	• Bayer Pharmaceuticals	None	None	None	• Plaintiff, alleged mitral valve dysfunction, 2009 • Defendant, retinal artery occlusion (stroke) after CABG, 2009 • Defendant, timely insertion of IABP after CABG, 2009 • Defendant, timely transport after acute aortic dissection, 2009 • Plaintiff, unexpected intra-abdominal hemorrhage and death after AVR, 2009	2.2.3 4.1 4.2 5.2.6
John G. Byrne	Vanderbilt University Medical Center: Division of Cardiac Surgery—Chairman of Cardiac Surgery	None	None	None	None	None	None	None
Joaquin E. Cigarroa	Oregon Health and Science University—Associate Professor of Medicine	None	None	None	None	None	None	None
Verdi J. DiSesa	John Hopkins Hospital, Division of Cardiac Surgery—Clinical Associate	None	None	None	None	None	None	None
Loren F. Hiratzka	Cardiac, Vascular and Thoracic Surgeons, Inc.—Medical Director of Cardiac Surgery	None	None	None	None	None	None	None
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AVR indicates aortic valve replacement; CABG, coronary artery bypass graft surgery; and IABP, intraaortic balloon pump.

APPENDIX 2. REVIEWER RELATIONSHIPS WITH INDUSTRY AND OTHER ENTITIES (RELEVANT)—2011 ACCF/AHA GUIDELINE FOR CORONARY ARTERY BYPASS GRAFT SURGERY

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Jeffrey Jacobs	Official Reviewer—ACCF/AHA Task Force on Data Standards	None	None	None	None	None	None
L. Kristin Newby	Official Reviewer—AHA	• AstraZeneca	None	None	• Eli Lilly* • GlaxoSmithKline†	None	None
Eric D. Peterson	Official Reviewer—ACCF/AHA Task Force on Performance Measures	• AstraZeneca	None	None	• BMS/sanofi-aventis† • Eli Lilly†	None	None
Richard J. Shemin	Official Reviewer—AHA	• Edwards Lifesciences	None	None	None	None	None
Hector Ventura	Official Reviewer—ACCF Board of Governors	None	• Actelion • Gilead	None	None	None	None
Thad F. Waites	Official Reviewer—ACCF Board of Trustees	None	None	None	None	None	None
T. Bruce Ferguson, Jr.	Organizational Reviewer—STS	None	None	None	None	None	None
Stephen E. Fremes	Organizational Reviewer—AATS	None	None	None	None	Merck	• Defendant, leaking thoracic aortic aneurysm, 2009 • Defendant, aortic dissection, 2009
Colleen G. Koch	Organizational Reviewer—SCA	None	None	None	None	None	None
Harold L. Lazar	Organizational Reviewer—AATS	None	None	None	None	None	None
Walter H. Merrill	Organizational Reviewer—STS	None	None	None	None	None	None

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Stanton K. Shernan	Organizational Reviewer—SCA	None	• Philips Healthcare	None	None	None	• Plaintiff, communication of echocardiography results, 2010
Joseph S. Alpert	Content Reviewer	• Bayer • Sanofi-aventis	None	None	None	None	None
Robert M. Califf	Content Reviewer	• AstraZeneca • Daiichi-Sankyo • GlaxoSmithKline • Medtronic • Sanofi-aventis	None	None	• Eli Lilly† • Bayer	None	None
Robbin G. Cohen	Content Reviewer	None	None	None	None	None	• Defendant, death after minimally invasive heart surgery, 2011 • Defendant, diagnosis of aortic dissection, 2010 • Plaintiff, renal failure and Aprotinin, 2010
Mark A. Creager	Content Reviewer—ACCF/AHA Task Force on Practice Guidelines	• AstraZeneca • Genzyme • Merck • Roche • Vascutek	None	None	• Merck	None	• Plaintiff, Fasudil Development: *Asahi Pharma v Actelion,* 2010
Steven M. Ettinger	Content Review—ACCF/AHA Task Force on Practice Guidelines	None	None	None	• Medtronic	None	None
David P. Faxon	Content Reviewer	• Sanofi-aventis	None	None	None	None	• Defendant, cath vascular access site complication, 2009
Kirsten E. Fleischmann	Content Reviewer	None	None	None	None	None	None
Lee Fleisher	Content Reviewer	None	None	None	• Pfizer	• AstraZeneca†	• Defendant, perioperative stroke, 2009
Anthony P. Furnary	Content Reviewer—ACCF Surgeons' Scientific Council	None	None	None	None	None	• Defendant, Bayer Corp. Trasylol litigation, 2009 to 2011
Valentin Fuster	Content Reviewer	None	None	None	None	None	None
John W. Hirshfeld, Jr.	Content Reviewer	• GlaxoSmithKline	None	None	None	None	None
Judith S. Hochman	Content Reviewer—ACCF/AHA Task Force on Practice Guidelines	• Eli Lilly • GlaxoSmithKline	None	None	None	None	None
James L. Januzzi, Jr.	Content Reviewer	• Roche	None	None	• Roche	None	None
Frederick G. Kushner	Content Reviewer—Vice Chair, 2012 STEMI Guideline Writing Committee	None	None	None	None	None	None
Glenn Levine	Content Review—Chair, 2011 PCI Guideline Writing Committee	None	None	None	None	None	None

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Donald Likosky	Content Reviewer	None	None	None	• Maquet† • Medtronic†	None	None
James J. Livesay	Content Reviewer—Southern Thoracic Surgical Association	None	None	None	None	None	• Defendant, acute aortic dissection, 2011 • Defendant, cardiac mortality review, 2010 • Defendant, heparin induced thrombocytopenia, 2010
Bruce W. Lytle	Content Reviewer—2004 CABG Guideline Writing Committee	None	None	None	None	None	None
Robert A. Marlow	Content Reviewer—2004 CABG Guideline Writing Committee	None	None	None	None	None	None
Rick A. Nishimura	Content Reviewer—ACCF Board of Trustees	None	None	None	None	None	None
Patrick O'Gara	Content Reviewer—Chair, 2012 STEMI Guideline Writing Committee	None	None	None	None	None	None
E. Magnus Ohman	Content Reviewer—ACCF/AHA Task Force on Practice Guidelines	• AstraZeneca • Bristol-Myers Squibb • Boehringer Ingelheim • Gilead Sciences • Merck • Pozen • Sanofi-aventis	• Boehringer Ingelheim • Gilead Sciences	None	• Daiichi-Sankyo • Datascope • Eli Lilly	None	None
John D. Rutherford	Content Reviewer	None	None	None	None	None	None
George A. Stouffer	Content Reviewer	None	None	None	None	None	• Defendant, review of malpractice claim, 2010
Mathew Williams	Content—ACCF Interventional Scientific Council	• Edwards Lifesciences • Medtronic	None	None	None	None	None

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AATS indicates American Association for Thoracic Surgery; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; CABG, coronary artery bypass graft surgery; PCI, percutaneous coronary intervention; SCA, Society of Cardiovascular Anesthesiologists; STEMI, ST-elevation myocardial infarction; and STS, Society of Thoracic Surgeons.

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APPENDIX 3. ABBREVIATION LIST

ACE = angiotensin-converting enzyme
ACS = acute coronary syndrome
AF = atrial fibrillation
AKI = acute kidney injury
ARB = angiotensin-receptor blockers
BMS = bare-metal stent
CABG = coronary artery bypass graft surgery
CAD = coronary artery disease
CKD = chronic kidney disease
CPB = cardiopulmonary bypass
DAPT = dual antiplatelet therapy
DES = drug-eluting stent
EF = ejection fraction
GDMT = guideline–directed medical therapy
ICU = intensive care unit
IMA = internal mammary artery
LAD = left anterior descending
LDL = low-density lipoprotein
LIMA = left internal mammary artery
LV = left ventricular
LVEF = left ventricular ejection fraction
MACE = major adverse coronary events
MI = myocardial infarction
NSTEMI = non–ST-elevation myocardial infarction
PAC = pulmonary artery catheter
PAD = peripheral artery disease
PCI = percutaneous coronary intervention
RCT = randomized controlled trial
SIHD = stable ischemic heart disease
SIRS = systemic inflammatory response system
STEMI = ST-elevation myocardial infarction
SVG = saphenous vein graft
TEE = transesophageal echocardiography
TIA = transient ischemic attack
TMR = transmyocardial laser revascularization
UA = unstable angina

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2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery
American College of Cardiology Foundation, American Heart Association Task Force on Practice Guidelines, American Association for Thoracic Surgery, Society of Cardiovascular Anesthesiologists, Society of Thoracic Surgeons, L. David Hillis, Peter K. Smith, Jeffrey L. Anderson, John A. Bittl, Charles R. Bridges, John G. Byrne, Joaquin E. Cigarroa, Verdi J. DiSesa, Loren F. Hiratzka, Adolph M. Hutter, Jr, Michael E. Jessen, Ellen C. Keeley, Stephen J. Lahey, Richard A. Lange, Martin J. London, Michael J. Mack, Manesh R. Patel, John D. Puskas, Joseph F. Sabik, Ola Selnes, David M. Shahian, Jeffrey C. Trost, and Michael D. Winniford
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EDITORIAL COMMENT

Antiplatelet Therapy and Coronary Artery Bypass Graft Surgery

A Fallow Land*

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Paris, France

Despite many advances, open heart surgery is still associated with the risks of bleeding and thrombotic events. Whether to continue antiplatelet therapy during surgery is often handled differently by different institutions, with little interpatient variability within an institution. This confusion is caused by the lack of scientific evidence, so that decisions are being based on individual or local experience, somewhat oriented by recommendations, but based mainly on expert opinion.

See page 1994

Interruption of antiplatelet therapy (APT). In coronary patients on single oral APT, discontinuation of APT, usually aspirin, exposes them to an increased risk of death (1). In stented coronary patients, discontinuation of APT, especially if done prematurely and/or when interruption concerns both antiplatelet agents, exposes them to an increased risk of stent thrombosis and mortality. Therefore, current guidelines have warned against premature and unjustified discontinuation of APT in coronary patients (2).

In contrast, coronary patients on APT undergoing coronary artery bypass graft (CABG) surgery are exposed to an excess of bleeding complications. Bleeding complications and transfusions have been associated with an excess of ischemic complications and mortality, at both short- and long-term follow-up (3,4). Therefore, current guidelines have increased physicians' awareness of the issue and proposed strategies to reduce the risk of bleeding. Concerning clopidogrel, it is currently recommended to stop treatment 5 to 7 days before CABG surgery on the basis of pharmacodynamic studies and a post hoc analysis of a large randomized trial in acute coronary syndrome (4). Background aspirin therapy is nowadays accepted for CABG surgery, although it was not the case many years ago. Concerns about bleeding were such that it resulted in the preoperative discontinuation of aspirin therapy until aspirin was shown to reduce mortality in CABG surgery (5).

Several reports have suggested that the bleeding risk could be kept under control during CABG surgery even with continuation of dual APT (6,7). Such a strategy would of course have the advantage of not exposing patients to recurrent ischemic events while withholding thienopyridine treatment and not postponing surgery for the only reason of active APT. Moreover, several reports have suggested in the past that APT may improve the post-operative outcome of patients undergoing CABG surgery. Aspirin prevented early post-operative graft occlusion and reduced mortality (5) and glycoprotein IIb/IIIa inhibitors were shown to reduce death or myocardial infarction in CABG patients when compared with placebo (8). Platelet consumption and dysfunction after cardiopulmonary bypass has been widely described with similarities to what was described for hemodialysis. Interestingly, both ticlopidin and clopidogrel have been shown to reduce the frequency of thrombosis of arteriovenous fistulae in patients undergoing hemodialysis (9,10). Recently, patients undergoing CABG surgery who were taking prasugrel, a thienopyridine more potent than clopidogrel, had a large excess of major bleeding complications compared with those taking clopidogrel (11.3% vs. 3.6%) in the randomized, double-blind TRITON (TRial to assess Improvement in Therapeutic Outcomes by Optimizing platelet inhibitioN) trial (11). However, mortality rates after CABG surgery tended to be lower in the prasugrel-treated patients than in the clopidogrel-treated patients. This disconnect between bleeding complications and mortality was further observed in the PLATO (PLATelet Inhibition and Patient Outcomes)-CABG study, which found a significant reduction of mortality with ticagrelor, a stronger $P2Y_{12}$ antagonist than clopidogrel, whereas bleeding and ischemic event rates were similar with clopidogrel and ticagrelor (12). These post hoc analyses have many biases, and the recommendations in both studies were to

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withhold APT for CABG surgery, which was of course difficult to control, leaving uncertainty as to the degree of platelet inhibition or recovery of platelet function at the time of surgery. Altogether, the literature on antiplatelet agents suggests that there may be an ischemic and/or mortality benefit with some degree of platelet inhibition in patients undergoing CABG surgery despite a possible risk of excess bleeding. The optimal degree of platelet inhibition for the best post-CABG risk/benefit ratio remains entirely unknown.

Controlling platelet activity for CABG surgery. Would information on residual platelet activity at the time of CABG surgery help identify patients at risk of further ischemic or bleeding complications? Is clopidogrel titration possible to maintain patient platelet reactivity in a predefined "optimal surgery window?" In this issue of the *Journal*, Kwak et al. (13) explore the relationship between platelet function after clopidogrel discontinuation and periprocedure blood loss. They correlated residual platelet reactivity before surgery and blood loss in 100 patients who interrupted clopidogrel before off-pump coronary artery bypass graft (OPCABG). The model of OPCABG allows accurate measurements of blood loss and limits post-operative thrombocytopenia and platelet dysfunction more frequently seen with cardiopulmonary bypass. They used the thromboelastography (TEG) platelet mapping assay (Ańemoscope Corp., Niles, Illinois) that measures platelet activation on the basis of blood coagulation and clot strength. It correlates with bleeding and may be used to guide transfusion after cardiac surgery but is not currently recommended for this indication (4). Limited data suggest that it can also identify patients at increased risk of ischemic events (14). The authors found that a persistent high level of platelet inhibition, as measured with the TEG platelet mapping assay at the time of surgery, was associated with a higher volume of blood loss irrespective of the delay between clopidogrel discontinuation and surgery. This finding suggests that recommendations of an average delay of discontinuation of APT before surgery (i.e., 5 days for clopidogrel) is not appropriate at the individual level. This is in line with what we know of the interindividual variability of response to clopidogrel, an inactive pro-drug that requires hepatic conversion into an active metabolite that binds to the platelet $P2Y_{12}$ receptor. The limits of the therapeutic window of platelet inhibition are still uncertain for percutaneous coronary intervention and unknown for CABG (Fig. 1).

What this study does not say is even more important than what it does say, and it should stimulate further studies. Is this test the best tool to identify the potential bleeders during or after surgery? Is the cutoff value of 70% obtained with the TEG platelet mapping assay the ideal threshold for the risk of bleeding? Is this value the same for on-pump surgery? How does it correlate with established point of care assays that have been used in clinical outcome studies performed in stented patients? Is there another threshold for the risk of ischemic events, and shall we now define an optimal surgery window for platelet reactivity to operate on patients (Fig. 1)? Can we improve the prognosis of CABG patients by a systematic monitoring of platelet function and operate when they reach such a predefined window of platelet reactivity?

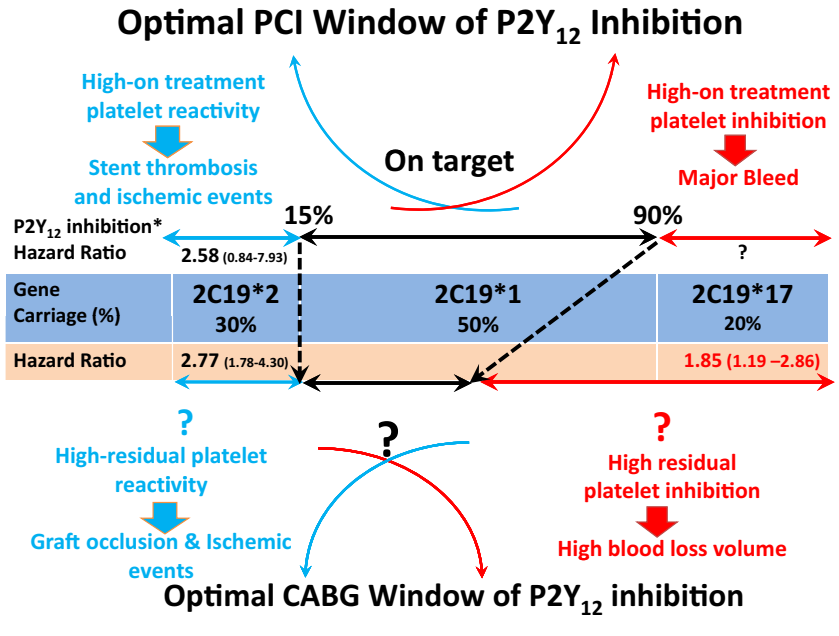

Figure 1 Optimal Window of Platelet Inhibition for PCI or CABG

Is there an optimal window of $P2Y_{12}$ inhibition for percutaneous coronary intervention (PCI) and coronary artery bypass graft (CABG) patients? Is the therapeutic window different? *% inhibition with VerifyNow.

A call for studies in CABG patients. Several randomized trials (NCT00661206, NCT00780156, NCT00977938, NCT00822536, and NCT00640679), totaling >35,000 patients, are evaluating the safety and efficacy of thienopyridine interruption after stenting to try to determine the best timing of discontinuation. Not a single randomized study has evaluated the safety and efficacy of clopidogrel interruption before CABG surgery. Despite the huge gap in knowledge and the lessons learned with aspirin, guidelines have validated the concept of clopidogrel interruption and provided the timelines for its withdrawal before surgery. This uncharted territory extends to the post-operative period in which similar uncertainties exist about the use of thienopyridines in patients with or without pre-operative acute coronary syndromes.

The new tools and the new drugs may help to clarify the path to better understanding and better management of these patients. The bedside assays to monitor platelet function may stimulate descriptive studies on what is currently performed and what could be new approaches in the pre-operative phase.

Bedside genetic testing is also an interesting way to predict on-treatment platelet reactivity and off-treatment residual platelet inhibition and thus anticipate perioperative bleeding and ischemic events. Although several studies have now clearly established the increased risk of ischemic events in carriers of the loss-of-function CYP2C19*2 genetic variant, recent evidence suggests that the gain-of-function CYP2C19*17 genetic variant is associated with an increased bleeding risk in clopidogrel-treated patients (Fig. 1). Whether the delay in clopidogrel discontinuation should be individualized according to the genetic profile requires further investigations. Rapid genetic testing is around the corner and using this information may improve the predictability of platelet function assays.

New drugs, such as cangrelor, an intravenous potent, reversible, and specific $P2Y_{12}$ purine receptor antagonist that blocks adenosine diphosphate–induced platelet activation and aggregation, will clarify management of these patients in the BRIDGE (Maintenance of Platelet Inhibition With Cangrelor) trial. In this randomized, double-blind study, patients scheduled for CABG surgery will receive from the day of clopidogrel interruption a cangrelor (or placebo) infusion to maintain levels of inhibition at least equivalent to those expected to be maintained if a thienopyridine (clopidogrel or ticlopidine) had not been discontinued, using the bedside VerifyNow $P2Y_{12}$ assay. The infusion will be discontinued 1 to 2 h before surgery, with the aim being to show that patients can undergo surgery without excessive bleeding perioperatively. Other reversible intravenous agents are being developed and may well fit the perioperative management of platelet reactivity in patients undergoing CABG surgery, possibly with simultaneous platelet function monitoring at the bedside.

We need to realize that the risk of bleeding associated with CABG surgery does not obviate the need for clinical trials evaluating other hard end points. A series of small studies, such as the one reported by Kwak et al. (13), could collectively draw awareness and lead to rigorous exploration of the platelet issues linked to CABG indication. The new diagnostic tools and the new drugs may help to generate concerted scientific action with anesthetists and cardiac surgeons.

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Key Words: clopidogrel ■ coronary artery bypass surgery ■ off-pump ■ transfusion.

EDITORIALS

Coronary Revascularization in Context

Richard A. Lange, M.D., and L. David Hillis, M.D.

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Do CABG and PCI result in similar outcomes? A recent review[3] of 23 randomized, controlled comparisons of CABG and PCI (by means of balloon angioplasty or bare-metal stenting) in approximately 10,000 patients showed that CABG was superior to PCI in relieving angina and averting repeat revascularization procedures. The rates of survival at 1, 5, and 10 years were similar for the two procedures, even though CABG carried a higher risk of stroke (1.2%, vs. 0.6% with PCI). However, most of the 23 studies did not involve patients with severe coronary artery disease (i.e., left main or three-vessel coronary artery disease) and did not use the latest revascularization techniques.

In this issue of the *Journal*, Serruys et al. describe the Synergy between PCI with Taxus and Cardiac Surgery (SYNTAX) trial[4] (ClinicalTrials.gov number, NCT00114972), in which 1800 patients with left main or three-vessel coronary artery disease were randomly assigned to undergo CABG or PCI (with drug-eluting stents) to determine which was the better revascularization strategy. Previously published studies comparing the two procedures in such patients were single-center, nonrandomized trials with relatively small numbers of patients, and the results were inconsistent: some[5] showed that CABG was associated with fewer major adverse events, whereas others[6-8] showed that the outcomes with CABG and with PCI were similar.

In the SYNTAX trial, patients treated with PCI involving drug-eluting stents were more likely than those undergoing CABG to reach the primary end point of the study — death from any cause, stroke, myocardial infarction, or repeat revascularization — within 12 months after randomization (17.8% of patients vs. 12.4%). In an analysis of secondary end points, the two treatment groups had similar rates of death from any cause, stroke, or myocardial infarction (7.6% for PCI and 7.7% for CABG). Patients undergoing PCI were more likely than those undergoing CABG to require repeat revascularization (13.5% vs. 5.9%) but were less likely to have a stroke (0.6% vs. 2.2%). The investigators do not discuss whether the strokes were related to the procedure or whether the risk of having a stroke was influenced by differences between the two groups in the occurrence of atrial fibrillation, use of aspirin or other antiplatelet agents, or presence of risk factors for atherosclerosis.

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The study has several notable strengths. First, it was a prospective, multicenter trial in which a large number of patients were enrolled at 85 centers in Europe and the United States. Second, it attempted to include "all comers" with left main or three-vessel coronary artery disease. In contrast to previously published comparisons of PCI and CABG, in which only about 10% of screened patients were included, the enrollment rate in the SYNTAX trial was impressively high, with 71% of screened patients enrolled in the randomized or registry cohorts. Third, the study used state-of-the-art CABG and PCI (with arterial grafts and drug-eluting stents, respectively), both with excellent results. Fourth, a "heart team" consisting of an interventional cardiologist and cardiac surgeon reviewed each subject's data (including findings on coronary angiography), after which they reached agreement on which procedure or procedures should be offered to that subject.

The study also has limitations. First and most important, the follow-up period was only 12 months; the outcomes of PCI and CABG over a longer period of follow-up in patients with severe coronary artery disease are unknown. Second, since most of the patients (78%) were men, it is unknown whether these findings are applicable to women. Third, the patients who underwent CABG were less likely to receive optimal medical therapy (i.e., statins, aspirin or other antiplatelet agents, and angiotensin-converting–enzyme [ACE] inhibitors or angiotensin II–receptor antagonists), which may have contributed to their increased risk of stroke.

How should revascularization be accomplished in a patient with left main or three-vessel coronary artery disease? All pertinent data, including that from diagnostic angiography, should be reviewed by a cardiac surgeon and interventional cardiologist to determine the likelihood of safe and effective revascularization with PCI and with CABG. To ensure this kind of thorough review, coronary revascularization should not be performed at the time of diagnostic angiography, thereby allowing the heart team sufficient time to review all the data, reach a consensus, and discuss the findings with the patient. In the SYNTAX trial, the time from diagnostic angiography to revascularization averaged 6.9 days in the PCI group and 17.4 days in the CABG group.

An occasional patient is unable or unwilling to take dual antiplatelet agents (aspirin and clopidogrel), which are necessary after placement of a drug-eluting stent. In others, complete revascularization can be accomplished much more effectively with CABG than with PCI. Approximately one third of the patients in the SYNTAX study had one of these two issues. Such patients should be encouraged to undergo CABG. Conversely, patients with serious coexisting conditions or vessels unsuitable for grafting (about 5% of patients in the SYNTAX study) are poor candidates for CABG; they should be encouraged to undergo PCI.

If safe and complete revascularization is feasible with either PCI or CABG — as was true in roughly 60% of the patients in the SYNTAX study — an assessment of coronary anatomical characteristics should be performed, and a SYNTAX score assigned.[9,10] The presence of complex coronary anatomical features (assigned a high SYNTAX score) identifies patients with an increased risk of a suboptimal outcome with PCI; they should be encouraged to undergo CABG. Conversely, patients with less complex coronary anatomical features (i.e., a low SYNTAX score) should be presented with the advantages and disadvantages of each procedure and allowed to choose between them. Irrespective of which procedure is performed, the patient should receive optimal medical therapy involving an antiplatelet agent (or agents), a statin, and an ACE inhibitor, if appropriate.

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The NEW ENGLAND JOURNAL of MEDICINE

Perspective Roundtable: CABG vs. Stenting: Clinical Implications of the SYNTAX Trial.

DR. THOMAS LEE: Welcome to a Perspective Roundtable of the *New England Journal of Medicine*. I'm Tom Lee, an associate editor of the *Journal*. And today I'll be here with two of my colleagues, discussing a trial that's just being released at the *Journal*'s Web site, the SYNTAX trial, which compares the impact of coronary-artery bypass graft surgery and percutaneous coronary intervention in patients with severe coronary disease.

On my right is Dr. David Hillis, chairman of medicine at the University of Texas Health Science Center at San Antonio. And on my left is Dr. Elizabeth Nabel, who's director of the National Heart, Lung and Blood Institute. Welcome to our Perspective Roundtable. And thank you for your insights today. Dave, why don't we start with you. And can you give our viewers a high level summary of the trial and the key results?

DR. DAVID HILLIS: This was an international, multicenter, randomized, controlled comparison of bypass surgery, CABG, versus PCI with drug-eluting stents in 1800 patients, all of them with left main or three-vessel coronary artery disease. They were randomized, as I mentioned, to one of those two therapies. They were then followed for one year, 12 months. And during that 12 months, the authors looked for an adverse event. Adverse events were defined as one of four: number one, all cause death; number two, myocardial infarction; number three, stroke; and number four, repeat revascularization. So, it was a combined end point of any one of those four events occurring within 12 months of randomization.

The main bottom-line results of the study was that, at one year, about 12% of the CABG patients had had one of these four adverse events. In contrast, 18% of the PCI patients had had one of those adverse events. So the bottom line conclusion of the authors was that CABG remains the standard of care for patients with left main and three-vessel coronary artery disease.

DR. LEE: Well, for people who just read the last couple lines of an abstract, that would be the message they walk away with, is that CABG seems to be the better approach. But it's more complicated than that. And Betsy, why don't you help us pick apart the outcomes that are used in this trial a little bit more.

DR. ELIZABETH NABEL: If we look at the primary end point, which Dr. Hillis articulated was a combination of death, MI, stroke and the need for revascularization, if we drill down further, there was no difference between the two groups in death, MI, and stroke at one year. The primary end point was really driven by an increased need for revascularization in the PCI group. So that is an important distinction that we must remember. Furthermore, if we look at the complication rate, there was a 1.6% higher incidence of stroke in the CABG group, compared to the PCI group.

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DR. LEE: Dave, I'm going to ask you, make that argument that CABG is the standard of care, the first choice for patients with severe coronary disease.

DR. HILLIS: Tom, I think that for patients with left main and three-vessel disease, CABG is certainly still the treatment of choice. The more complex the coronary anatomy — that is, the higher the SYNTAX score — the better the patients did with CABG as opposed to PCI. If the SYNTAX score was low, the two therapies seemed similar to one another.

Now secondly, I think it is important that patients who undergo CABG be treated with intensive medical therapy. One of the reasons that the stroke rate may have been higher in the CABG patients than in those randomized for PCI, was that the CABG patients were not treated as intensively with platelet inhibitors, ace inhibitors, and statins. So, if the patients go to surgery, one should not neglect their medical therapy.

DR. LEE: And Betsy, the case for thinking first about coronary intervention?

DR. NABEL: I think that there are patients who have complex coronary anatomy who would prefer to undergo PCI. They would prefer to accept the possibility of requiring a repeat revascularization, but do not want to subject themselves to an increased risk for stroke or to an increased recovery time that might occur from a sternotomy. So in this case, cost and quality of life might be important issues that would sway them towards preferring PCI.

DR. LEE: So, in the real world currently, I guess one reason why a lot of patients are getting the strategy not recommended by the conclusion, that is, going right to angioplasty, is the decisions are being made while the patient is lying on the table. But, in this case, there was time to step back and weigh both.

DR. HILLIS: Absolutely. I think it's an important point of the study, and that is, that what they referred to as a — quote, unquote — heart team sat down and, in a very detailed fashion, did a complete and thorough evaluation of each patient, including the patient's angiogram, after — and this team was composed of a cardiac surgeon and an interventional cardiologist. And they came to a consensus agreement on which of the two therapies would be better for that individual patient. In other words, the intervention was not done at the same time, or linked closely in time to the angiogram.

DR. LEE: Now Betsy, this trial was not funded by the NHLBI. This trial was funded by a manufacturer of drug-eluting stents. So one of the first things that a lot of readers do is look — could that have influenced the design of the trial in any way? What's your comment on that?

DR. NABEL: I think two points are salient, Tom. First is the trial design actually stacked the cards against the PCI intervention by combining both the hard end points of death, MI, and stroke, and the soft end point, the need for revascularization, into a combined primary end point. If the trial design had separated those end points, the primary end

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point would have been equivalent, and there would have been a difference in the secondary end point. So, in other words, the device manufacturer, in some ways, stacked the cards against themselves.

But the second important point is this study is an example of comparative effectiveness research, which is receiving a lot of attention in Washington, DC, these days. Comparative effectiveness research is a rigorous evaluation of two different types of treatments or two different approaches towards the same medical condition and evaluates the effectiveness of both of those approaches. We're going to see much more research in this area coming down the pike. But I think the industry is to be congratulated for conducting this type of heads-on comparison in the manner in which they did.

DR. LEE: The pro-angioplasty approach points out the 1.6% higher stroke rate in bypass surgery. But when you really started looking carefully at, you know, Table 3 of the paper, which has the outcomes in some detail, the cardiac mortality is 1.6% higher in the angioplasty group than the bypass group. The total mortalities are similar, but the cardiac mortality is higher. Your comments on that?

DR. NABEL: Well, I think it's an interesting debate, Tom. On the one hand, CABG led to more complete revascularization with a higher stroke rate and, I'd also point out, a higher noncardiac mortality rate. On the other hand, we know PCI leads to less complete revascularization, perhaps a numerical difference in cardiac mortality, but a smaller stroke rate, and certainly easier on the individual, in terms of procedure recovery time and other factors.

I think subsequent studies will be looking at greater detail the differences between these groups and these factors, looking at cost-effectiveness, as well as quality-of-life issues. It may be that we're really — what we're coming down to, Tom, is a discussion between the patient and the medical and surgical team, really focusing on patient preferences, complexity of coronary anatomy, and potential risks and benefits, depending upon their medical state and their comorbidities.

DR. LEE: Well Betsy, there are a lot of unanswered questions, clearly. And you probably have as good or better insight than anyone in the country about what's coming, in the way of new trials to address those questions. So your summary of the big questions that need to be answered, and the trials that might answer them for us?

DR. NABEL: The NHLBI is now sponsoring the Freedom trial, which is a head-on comparison in diabetic patients between CABG and PCI. In this study, the primary end point will be the hard clinical end points of death, MI, and stroke. And need for revascularization will be a secondary end point. There will be intricate neurological assessments at various times along the study, so that we can get not only the stroke rate, but more subtle cognitive effects that might occur as the result of CABG or PCI.

In addition, we'll be looking at cost-effectiveness and quality-of-life measures in patients receiving both therapies. And finally, we'll have a 4-year follow-up period, so that we'll be able to see the outcomes over a longer period of time. So again, we need to understand, particularly in diabetic patients, whether CABG versus PCI achieves improved clinical outcomes.

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DR. LEE: Well, you know, the issues are complicated. Medicine's complicated. And I think that patients should have a chance to articulate their preferences and weigh the risk of stroke versus risk of other kinds of outcomes. The SYNTAX trial will surely make those discussions much more informed and probably make them happen much more reliably. And I want to thank you two for your comments, because I think that they will help guide many of our audience members in those discussions. Thanks very much.

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Clinical Outcomes and Stent Thrombosis Following Off-Label Use of Drug-Eluting Stents

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Context Clinical trials that have excluded patients at high risk for cardiac events have led to commercial labeling approval of drug-eluting stents; nevertheless, such high-risk patients commonly undergo stent placement in clinical practice. The degree to which they experience cardiac events at a higher rate than non–high-risk patients is unclear.

Objective To assess the rates of major adverse cardiac events during the index admission and 1 year after the implantation of drug-eluting stents in patients with high-risk angiographic and clinical features.

Design, Setting, and Patients From July 2004 to September 2005, consecutive patients who underwent attempted stent placement at 42 different hospitals throughout the United States were enrolled in a prospective multicenter registry. We analyzed outcomes of 3323 patients who received at least 1 drug-eluting stent for a reason other than acute ST-segment elevation myocardial infarction. The study population was divided into 2 groups based on presence of at least 1 of 9 off-label characteristics based on the current US Food and Drug Administration–approved indications for sirolimus- and paclitaxel-eluting stents.

Main Outcome Measures The composite clinical outcomes of death, myocardial infarction, or target vessel revascularization during the index admission and death, myocardial infarction, or target lesion revascularization at 1 year were evaluated.

Results Of the 3323 patients, 1817 (54.7%) had at least 1 off-label characteristic. During the index hospitalization, the composite clinical outcome occurred in 198 (10.9%) of patients in the off-label group and 76 (5.0%) of patients in the on-label group (adjusted odds ratio, 2.32; 95% confidence interval [CI], 1.75-3.07; $P<.001$). At 1 year, the composite clinical outcome occurred more often in the off-label group compared with the on-label group; 309 (17.5%) vs 131 (8.9%) (adjusted hazard ratio [HR], 2.16; 95% CI, 1.74-2.67; $P<.001$). Stent thrombosis also occurred more frequently among patients in the off-label group during the initial hospitalization (8 [0.4%] vs 0) and at 1 year: 29 (1.6%) vs 13 (0.9%), adjusted HR, 2.29 (95% CI, 1.02-5.16; $P=.05$).

Conclusions Compared with on-label use, off-label use of drug-eluting stents is associated with a higher rate of adverse outcomes during the index admission and at 1 year. Stent thrombosis occurred predominantly in patients who underwent off-label drug-eluting stent implantation. Clinicians should be cautious about extrapolating the benefits of drug-eluting stents over bare-metal stents observed in randomized clinical trials to higher-risk clinical settings that have not been assessed.

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After the US Food and Drug Administration (FDA) approval of the sirolimus-eluting stent in April 2003[1] and the paclitaxel-eluting stent in March 2004,[2] drug-eluting stents have been used in the vast majority of percutaneous coronary interventions (PCIs) in the United States. FDA approval for commercialization was based on data from several randomized controlled trials demonstrating reductions of in-stent restenosis and target vessel revascularization among patients receiving drug-eluting stents.[3,4] Between April 2003 and December 2004, the proportion of procedures using drug-eluting stents increased from 19.7% to 78.2% in the United States.[5]

Common clinical situations generally associated with above-average risk were excluded from the original pivotal trials of drug-eluting vs bare-metal stents. Consequently, the original FDA label-approved indications for sirolimus-eluting stents were de novo lesions no longer than 30 mm in native coronary arteries with reference vessel diameters of at least 2.5 mm to at most 3.5 mm[1] and for paclitaxel-eluting stents de novo lesions no longer than 28 mm in native coronary arteries at least 2.5 to at most 3.75 mm in diameter.[2] In view of the widespread use of drug-eluting stents, however, several important questions are still un-

See also pp 1992 and 2028.

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answered concerning their efficacy and safety in broader clinical practice.

The EVENT (Evaluation of Drug Eluting Stents and Ischemic Events) registry was launched shortly after original approval of drug-eluting stents and is a collaborative effort to assess the contemporary practice of stenting by performing a prospective evaluation of unselected patients undergoing implantation of an approved intracoronary stent in more than 40 centers (74% academic, median PCI volume 1400/y) in the United States.[6] To test the hypothesis that off-label use of these stents is associated with higher rates of cardiac events than approved (on-label) use, we assessed the frequency of off-label drug-eluting stent implantation and compared the rates of adverse clinical and procedural outcomes in patients undergoing on-label vs off-label implantation within the EVENT registry.

Table 1. Frequency of Off-Label Criteria*

Criteria for Off-Label Use	No. (%) of Patients (n = 1817)
>1 Lesion treated	1073 (59.1)
Total stent length ≥36 mm	975 (53.7)
Bifurcation lesion	473 (26.0)
Lesion in coronary artery bypass graft surgery	173 (9.5)
Baseline creatine kinase-MB >3 ULN	118 (6.5)
Stenosis preprocedure, 100%	112 (6.2)
Maximum balloon diameter >4 mm	76 (4.2)
Ejection fraction <25%	77 (4.2)
Unprotected LM intervention	20 (1.1)

Abbreviations: LM, left main coronary artery; ULN, upper limit of normal.
*Criteria are not mutually exclusive.

METHODS

The methods and population of EVENT have been described.[6] Patients undergoing attempted implantation of an approved intracoronary stent were eligible; enrollment of consecutive patients was strongly encouraged using previously enumerated strategies. The current analysis includes patients enrolled in the first 2 waves of the registry. Data about patient characteristics, presentation, and treatment were collected prospectively on standardized case report forms and submitted to the data coordinating center. Creatine kinase (CK) and CK-MB levels were assessed at baseline and every 8 hours for a minimum of 2 samples after the procedure and assayed using each site's clinical laboratory and reference values. If myocardial infarction (MI) was suspected clinically at a later point, additional biomarkers were obtained.

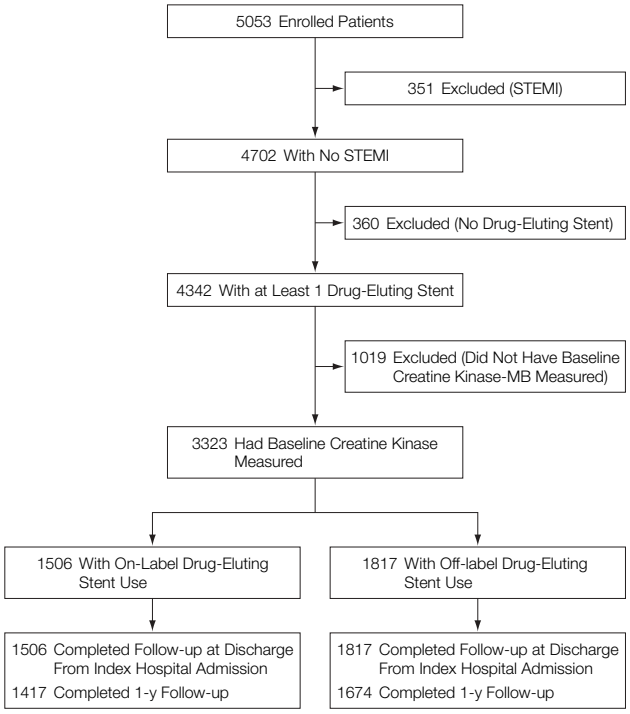
Patients were contacted by telephone at 6 and 12 months after the index PCI. Events noted at follow-up included stent thrombosis, death, revascularization, MI, and noncardiac surgery. The use of aspirin and clopidogrel was also assessed at each time point. The study protocol was approved by ethical review committees at all participating institutions; all patients provided written informed consent.

Patient Population

For the present analysis, we included all patients who underwent PCI for reasons other than ST-elevation MI, had baseline CK-MB measured, and received at least 1 drug-eluting stent in the first 2 waves of EVENT. Patients who received a bare-metal and 1 or more drug-eluting stents were analyzed (as specified in the study protocol) as having received a drug-eluting stent and were included in the current analysis while 339 patients (6.7%) receiving bare-metal stents only and 48 (0.9%) in whom no stent could be implanted were not included.

Patients were divided into 2 groups based on the presence of at least 1 of 9 characteristics that would have excluded them from the pivotal clinical trials submitted for the current label approvals of drug-eluting stents. Because the clinical characteristics required for enrollment in the Sirolimus-Coated Bx Velocity Balloon-Expandable Stent in the Treatment of Patients With de novo Coronary Artery Lesions (SIRIUS) and TAXUS IV trials[3,4] differed slightly, an amalgamated definition of off-label characteristics was adopted (TABLE 1). Patients not meeting at least 1 of these criteria were designated as the on-label group.

Figure 1. Study Flow Diagram



STEMI indicates ST-segment elevation myocardial infarction.

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Definitions, Adjudication of Events, and Study Outcomes

The primary end points were the composite of death, MI, or target vessel revascularization during the index hospitalization and death, MI, or target lesion revascularization at follow-up. The definition of MI was elevation of CK-MB or CK at least 3 times the local upper limit of normal with preference given to the MB values, or persistent ST-segment elevation greater than 1 mm in 2 contiguous electrocardiographic limb leads or greater than 2 mm in 2 contiguous precordial leads. For patients whose CK-MB (or CK) level was elevated at baseline, an increase of at least 2-fold compared with the baseline was also required.

Suspected MIs were adjudicated by 2 independent cardiologists without knowledge of the label status of the patient. Additional end points included death, coronary artery bypass graft surgery, repeat PCI, and major bleeding (defined by the Thrombolysis in MI [TIMI] criteria).[7] Lesion complexity[8] and angiographic success (residual stenosis <20% and TIMI grade 3 flow) were determined by the operator, as were stent thromboses. Repeat revascularization procedures were categorized by investigators as urgent or planned.

Statistical Methods

Continuous variables were compared with the *t* test. Dichotomous or nominal categorical variables were compared with the χ^2 test with normal approximation or Fisher exact test when appropriate, while ordinal variables were compared with Wilcoxon rank sum test. To test the association between label status and in-hospital clinical outcomes, odds ratios and their 95% confidence intervals (CIs) were calculated using logistic regression. For 6-month and 12-month clinical outcomes, hazard ratios (HRs) and their 95% CIs were calculated using Cox proportional hazards regression to test the association between label status and outcomes. Kaplan-Meier estimates were used to present event rate graphs for the in-hospital composite end point of death, MI, or target vessel revascularization and of the 6- and 12-month composite end points of death, MI, or target lesion revascularization. Event time distributions were compared using the log-rank test.

Logistic regression was used to identify predictors of in-hospital composite end point of death, MI, or target vessel revascularization and Cox proportional hazards regression was used to identify predictors of the 12-month composite end point of death, MI, or target lesion revascularization. The variables age, sex, diabetes, congestive heart failure, renal dysfunction (creatinine >2 mg/dL [>176.8 µmol/L]), acute coronary syndrome indication, and weight were considered in multivariable analyses as potential predictors. A list of significant variables ($P<.10$) using backward stepwise regression with stay criterion of .10 was generated. The variable *label*

Table 2. Baseline Clinical Characteristics of the Study Population*

	Off-Label (n = 1817)	On-Label (n = 1506)	*P* Value
Age, mean (SD), y	64.25 (11.33)	63.81 (11.14)	.26
Male	1324 (72.9)	1506 (65.9)	<.001
Diabetes	645 (35.6)	515 (34.2)	.43
Hypertension	1425 (78.7)	1174 (78.1)	.64
Hyperlipidemia	1359 (75.8)	1115 (74.7)	.45
Current smoking	413 (23.0)	357 (24.0)	.53
Renal dialysis	23 (1.3)	17 (1.1)	.72
Stroke	146 (8.1)	130 (8.7)	.55
Congestive heart failure	195 (10.8)	128 (8.5)	.03
Peripheral arterial disease	179 (10.0)	140 (9.4)	.57
MI	674 (37.8)	434 (29.1)	<.001
PCI	657 (36.5)	573 (38.3)	.29
Prior CABG	495 (27.3)	230 (15.4)	<.001
Procedure indication			
Chronic stable angina	390 (21.5)	335 (22.2)	.59
Positive stress test	644 (35.4)	583 (38.7)	.05
Acute coronary syndromes	698 (38.4)	505 (33.5)	.004
STEMI (primary or rescue PTCA)	0	0	
Other	235 (12.9)	182 (12.1)	.49
Extent of procedure, No.			
Lesions per patient			
Mean (SD)	1.74 (0.73)	1 (<1)	
Median (25th-75th percentile)	2 (1-2)	1 (1-1)	
Vessels per patient.			
Mean, (SD).	1.3 (0.490)	1 (<1)	
Median (25th-75th percentile)	1 (1-2)	1 (1-1)	
ACC/AHA type C lesion	593 (32.9)	177 (11.9)	
Drug-eluting stents type			
Sirolimus-eluting stent	1020 (56.1)	738 (49.0)	<.001
Paclitaxel-eluting stent	898 (49.4)	770 (51.1)	.33
Additional BMS	128 (7.0)	8 (0.5)	<.001
Medications at discharge			
Warfarin	73 (4.1)	71 (4.8)	.34
Statin	1434 (80.6)	1183 (79.8)	.58
β-Blocker	1390 (78.1)	1040 (70.2)	<.001
Calcium channel blocker	333 (18.7)	261 (17.6)	.42
ACE inhibitor	881 (49.5)	662 (44.7)	.006

Abbreviations: ACC/AHA, American College of Cardiology/American Heart Association; ACE, angiotensin-converting enzyme; BMS, bare-metal stent; CABG, coronary artery bypass graft surgery; CVA, cerebrovascular accident; DES, drug-eluting stent; MI, myocardial infarction; PCI, percutaneous coronary interventional; PTCA, percutaneous transluminal coronary angioplasty; STEMI, ST-segment elevation MI.
*All variables are presented as absolute numbers (percentage) unless otherwise stated.

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status was then forced into the regression model, which included the significant variables from the backward stepwise logistic regression model to assess the significance of label use in the presence of other significant predictors. To explore the role of antiplatelet therapy on late events, patients were categorized as receiving or not receiving dual antiplatelet therapy (combined aspirin and clopidogrel) at 6 or 12 months. Dual antiplatelet therapy status was subsequently forced into the model to determine whether it exerted an influence, in addition to label status, on the risk of a clinical event. Interaction terms and their 95% CIs were also determined for dual antiplatelet therapy status and label status for each of the outcomes. In a separate analysis, we used multiple logistic regression to identify which off-label characteristics were independently associated with ischemic complications during the index hospitalization and the 6-month and 12-month follow-up periods.

All statistical analyses were performed using SAS 8.2 (SAS Institute, Cary, NC). Unless specified otherwise, a 2-tailed *P* value of ≤.05 was considered statistically significant.

Table 3. Periprocedural Use of Clopidogrel, Heparin, Glycoprotein IIb/IIIa Inhibitors, and Direct Thrombin Inhibitors

	No. %		
	Off-Label (n = 1817)	On-Label (n = 1506)	*P* Value
Clopidogrel timing			
Any preprocedure	1008 (55.5)	840 (55.8)	
Postprocedure only	662 (36.5)	532 (35.3)	.94
None given	141 (7.8)	130 (8.6)	
Clopidogrel loading			
Chronic therapy >1 wk before treatment	531 (29.2)	482 (32.0)	.08
Loading dose			
≥300 mg at least 6 h before PCI	133 (7.3)	76 (5.0)	.007
≥600 mg at least 2 h before PCI	57 (3.1)	48 (3.2)	.93
Clopidogrel loading dose given preprocedure, mg			
<300	10 (0.6)	6 (0.4)	
300-599	266 (14.6)	174 (11.6)	.15
600	199 (11)	178 (11.8)	
Heparin pre-PCI	139 (7.6)	104 (6.9)	.41
Heparin during PCI, U/kg	1159 (63.8)	892 (59.2)	.007
<70	726 (40)	584 (38.8)	.50
70-99	315 (17.3)	246 (16.3)	.46
>99	118 (6.5)	62 (4.1)	.003
Direct thrombin inhibitor	657 (36.2)	643 (42.6)	<.001
Peak ACT, mean (SD), s	271 (62)	271 (66)	.85
GP IIb/IIIa antagonist			
Pre-PCI	109 (6)	46 (3.1)	<.001
Post-PCI infusion	775 (41.2)	529 (35.1)	<.001
No clopidogrel prior or loading dose and no Gp IIb/IIIa antagonist	57 (3.1)	55 (3.7)	.41

Abbreviations: ACT, activated clotting time; GP, glycoprotein; PCI, percutaneous coronary interventional; PTCA, percutaneous transluminal coronary angioplasty.

Table 4. Acute Angiographic Complications*

Angiographic Complications	Off-Label (n = 1817)	On-Label (n = 1506)	Unadjusted OR (95% CI)	*P* Value
Distal embolization	6 (0.3)	1 (0.1)	4.99 (0.60-41.46)	.14
Abrupt closure	8 (0.4)	5 (0.3)	1.33 (0.43-4.07)	.78
New thrombus	10 (0.6)	1 (0.1)	8.33 (1.06-65.14)	.02
No reflow	14 (0.8)	3 (0.2)	0.26 (0.07-0.90)	.03
Side-branch occlusion	50 (2.8)	12 (0.8)	3.52 (1.87-6.64)	<.001
Dissection	74 (4.1)	19 (1.3)	3.32 (2.00-5.53)	<.001
Total	162 (8.9)	42 (2.7)	3.49 (2.46-4.95)	<.001

Abbreviations: CI, confidence interval; OR, odds ratio.
*More than one angiographic complication could occur in a single patient.

RESULTS

Between July 2004 and September 2005, 5053 patients were enrolled in waves 1 and 2 of EVENT. Of the 3323 patients eligible for inclusion in the current analysis (FIGURE 1), 1817 (54.7%) had at least 1 off-label criterion. Among the latter group, 784 (43.1%) had 2, and 238 (13.2%) had 3 or more off-label characteristics. Similar proportions of patients in each wave of the registry were categorized as on-label and off-label. Follow-up was completed in 3323 (100%) patients at the time of discharge from index admission and in 3091 (93.2%) patients at 1 year.

Clinical and Angiographic Characteristics

The most common off-label characteristics were multilesion PCI, stent length of at least 36 mm, and treatment of a bifurcation lesion (Table 1.) Male sex, prior congestive heart failure, prior MI, and previous coronary artery bypass surgery graft surgery were more common in the off-label group. Patients in the off-label group were more likely to have acute coronary syndromes or congestive heart failure and less likely to have a positive stress test as indications for intervention and to receive a sirolimus-eluting stent or an additional bare-metal stent (TABLE 2).

Use of a 300 mg loading dose of clopidogrel 6 or more hours prior to the procedure or upstream glycoprotein IIb/IIIa antagonist use were slightly more common among the off-label group. Direct thrombin inhibitors were used less commonly in the off-label group. Peak activated clotting times were not different between groups (TABLE 3).

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Angiographic Outcomes and Events During Index Hospitalization

Angiographic success rates exceeded 97% in each group. Acute angiographic complications were more common in the off-label group (TABLE 4). All episodes of stent thrombosis during hospitalization occurred in the off-label group (8 [0.4%]) vs 0 [0%]).

The primary composite outcome occurred more often in the off-label group (TABLE 5). This difference was primarily due to a higher frequency of MI in the off-label group. Both large and small periprocedural infarctions were more common in the off-label group. Major bleeding occurred in 5 (0.3%) of 1817 patients in the off-label group vs 7 (0.5%) of 1506 patients in the on-label group and blood transfusion occurred in 40 (2.2) of 1817 in the off-label group and 22 (1.5%) of 1506 in the on-label group.

Outcomes at 1 Year

At one year, there was no difference in mortality between the groups. The composite outcome occurred more often in the off-label group: 309 (17.5%) vs 131 (8.9%), adjusted HR, 2.16 (95% CI, 1.74-2.67). Stent thrombosis also occurred more frequently in off-label patients: 29 (1.6%) vs 12 (0.9%) multivariable adjusted HR, 2.29 (95% CI, 1.02-5.16; $P<.001$; (FIGURE 2 and TABLE 6). Use of clopidogrel and aspirin was more than 75% in both groups at 12 months. When dual antiplatelet therapy status was forced into the model, there was little change in the excess risk associated with label status for the composite end point (adjusted HR, 2.17; 95% CI, 1.71-2.74; $P<.001$) or for stent thrombosis (adjusted HR, 2.63; 95% CI, 1.12-6.15, $P=.03$). Similarly, when 6-month dual antiplatelet status was forced into the model for 12-month outcomes, the adjusted odds ratios were very similar (for the composite end point HR, 2.24; 95% CI 1.75-2.89, and for stent thrombosis adjusted HR, 2.76; 95% CI, 1.18-6.48). There was no evidence of interaction between label status and concurrent dual antiplatelet therapy status, nor between 6-month dual antiplatelet therapy status for any of the outcomes at 6 or 12 months.

Characteristics Predicting Clinical Outcomes

Off-label drug-eluting stents use was independently associated with an increased risk of ischemic complications during the index hospitalization and at 1 year (TABLE 7). When individual off-label characteristics were subsequently forced into the model, stent length of 36 mm or longer, ejection fraction of less than 25%, and coronary bypass graft surgery lesions remained independent predictors of the composite end point at 1 year (FIGURE 3).

COMMENT

The first 2 waves of EVENT provided a unique opportunity to evaluate the contemporary use of drug-eluting stents as they were introduced into clinical practice. In this study we assessed the use of drug-eluting stents, and associated clinical and procedural outcomes, in common clinical settings not tested in the pivotal randomized trials. In contrast to other administrative and postmarket surveillance registries, periprocedural CK-MB levels, and detailed pharmacological data were collected routinely.

Our first key finding is that among unselected patients undergoing drug-eluting stent placement in contemporary practice, off-label use outnumbered

Table 5. Major Adverse Cardiac Events Between Index PCI and Discharge

End Point	Off-Label Index Admission (n = 1817)	On-Label Index Admission (n = 1506)	Adjusted OR (95% CI)	*P* Value‡
Death	5 (0.3)	1 (0.1)	3.67 (0.42-31.8)*	.24
MI	164 (9.0))	56 (3.7)	2.68 (1.95-3.60)*	<.001
Any CK-MB elevation	614 (34.3)	265 (18.1)	2.37 (2.01-2.80)†	<.001
CK-MB >5× ULN	149 (8.3)	35 (2.4)	3.72 (2.55-5.41)†	<.001
CK-MB >10× ULN	79 (4.4)	12 (0.8)	5.6 (3.04-10.32)†	<.001
TVR	46 (2.5)	21 (1.4)	1.62 (0.95-2.75)*	.08
Death, MI, or TVR	198 (10.9)	76 (5.0)	2.32 (1.75-3.07)*	<.001
Stent thrombosis	8 (0.4)	0		

Abbreviations: CI, confidence interval; CK, creatine kinase, MI, myocardial infarction; OR, odds ratio; TVR, target vessel revascularization; PCI, percutaneous coronary intervention; ULN, upper limit of normal.
*Adjusted for age, sex, weight, diabetes, congestive heart failure, renal dysfunction (creatinine >2 mg/dL [>176.8 µmol/L]) and acute coronary syndromes.
†Adjusted for presence of baseline creatine kinase-MB elevation.
‡Adjusted *P* value based on logistic regression analysis.

Table 6. Major Adverse Cardiac Events at 6 and 12 Months

	Off-Label	On-Label	Adjusted HR (95%CI)*	*P* Value
6 Months	(n = 1721)	(n = 1437)		
Death	29 (1.7)	13 (0.9)	1.75 (0.86-3.56)	.12
MI	180 (10.5)	64 (4.5)	2.47 (1.84-3.32)	<.001
TLR	87 (5.1)	30 (2.1)	2.50 (1.62-3.85)	<.001
Death, MI, TLR	253 (14.7)	97 (6.8)	2.33 (1.82-2.97)	<.001
Stent thrombosis	20 (1.2)	6 (0.4)	2.81 (1.03-7.63)	.04
12 Months	(n = 1770)	(n = 1474)		
Death	54 (3.1)	31 (2.1)	1.36 (0.85-2.17)	.10
MI	194 (11)	78 (5.3)	2.20 (1.68-2.89)	<.001
TLR	112 (6.3)	36 (2.4)	2.76 (1.87-4.06)	<.001
Death, MI, TLR	309 (17.5)	131 (8.9)	2.16 (1.74-2.67)	<.001
Stent thrombosis	29 (1.6)	13 (0.9)	2.29 (1.02-5.16)	.05

Abbreviations: CI, confidence interval; HR, hazard ratio; MI, myocardial infarction; TLR target lesion revascularization.
*Adjusted for age, sex, weight, diabetes, congestive heart failure, renal dysfunction (creatinine >2 mg/dL [>176.8 µmol/L]) and acute coronary syndromes.

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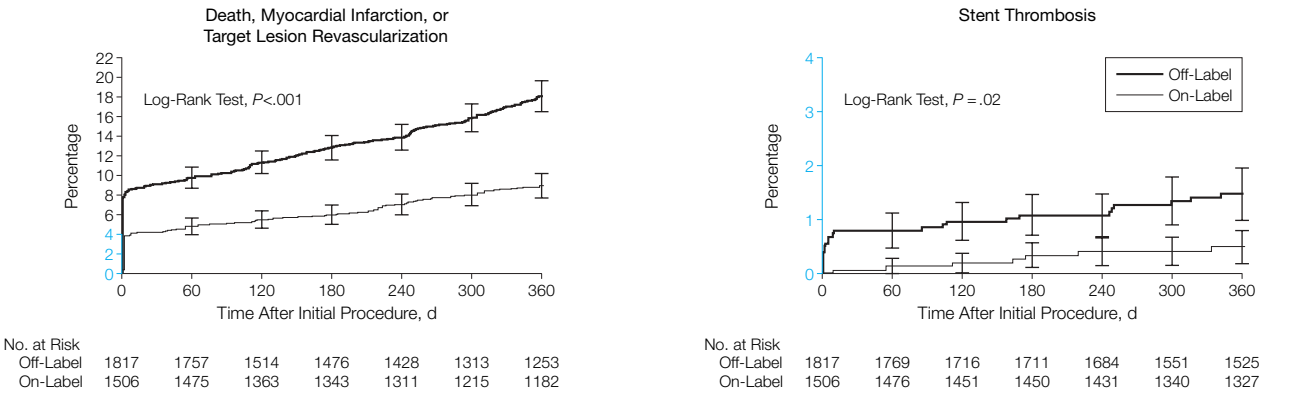
Figure 2. Kaplan-Meier Survival Curves of Primary Composite End Points



Error bars indicate 95% confidence intervals. Y-axis intervals shown in blue indicate range from 0 to 4.

Table 7. Independent Clinical Predictors of Clinical Outcomes

Predictor	OR (95% CI)*	*P* Value
Death/MI/TVR during the index hospitalization (n = 3323)		
ACS, present vs absent	1.34 (1.04-1.72)	.02
Diabetes, present vs absent	0.76 (0.58-0.99)	.04
Label, off-label vs on-label	2.28 (1.73-3.00)	<.001
	HR (95% CI)†	
Death/MI/TLR at 12 mo (n = 3091)		
Sex, male vs female	0.73 (0.6-0.89)	.002
Congestive heart failure	1.04 (1.04-1.82)	.02
Label, off-label vs on-label	2.21 (1.78-2.75)	<.001

Abbreviations: ACS, acute coronary syndromes; CI, confidence interval; HR, hazard ratio; MI, myocardial infarction; OR, odds ratio, TLR, target lesion revascularization; TVR, target vessel revascularization.
*Predictors were chosen by backward stepwise regression model using a stay criterion of 0.1.
†Predictors were chosen by backward stepwise Cox Proportional Hazard Model using a stay criterion of 0.10. Independent variables: age, sex, weight, diabetes, congestive heart failure, renal dysfunction (creatinine >2 mg/dL [>176.8 µmol/L]), and ACS indication.

on-label use. This proportion would have been even higher had patients undergoing primary PCI for ST elevation MI been included in this analysis. Moreover, we found that despite high rates of angiographic success, patients with 1 or more off-label characteristics who received at least 1 drug-eluting stents were more likely to experience an angiographic complication or an adverse cardiovascular event than patients treated for only on-label indications—differences that persisted after adjustment for a broad range of baseline variables. Indeed, off-label status was the strongest independent predictor of both in-hospital and 1-year adverse cardiac events in the multivariate model.

Off-label implantation of drug-eluting stents was also associated with a higher risk of stent thrombosis. All of the episodes of in-hospital stent thrombosis occurred in the off-label group, while in the interval between hospital discharge and 1-year follow-up, the differences in thrombosis rates appeared to narrow.

Comparison With Other Contemporary Data

The American College of Cardiology National Cardiovascular Data Registry (ACC-NCDR) reported that off-label use of drug-eluting stents was associated with a low rate of short-term adverse events compared with results predicted using a previously validated model.[9] Several factors may explain the differences between ACC/NCDR results and our findings. First, the definition of off-label use in the former study was less inclusive than that used in the current analysis. In contrast to ACC-NCDR, EVENT required rigorous assessment for periprocedural MI by evaluation of serial cardiac enzymes. As a result, adverse event rates in EVENT were substantially higher than those detected in most other "real-world" registries that have used less rigorous ascertainment techniques. Several small randomized trials and registries have assessed the utility of drug-eluting stents in a variety of lesion subsets that were not included in the pivotal clinical trials.[10-13] Enrollment in these studies was limited to specific lesion characteristics, while most patients in the off-label group in EVENT had multiple off-label characteristics, resulting in a higher acuity population than was represented in the lesion-specific trials.

Risk of Off-Label Use of Drug-Eluting Stents in Real-Life Settings

The risk associated with off-label use of drug-eluting stents was not limited to the periprocedural period, but continued to accrue after hospital discharge. Indeed, between discharge and 1-year, the composite outcome of death, MI, and target vessel revascularization occurred in 6.6% of patients in the off-label group and 3.9% in the on-label group. Only a small proportion of this difference could be attributed to late stent thrombosis. It has been observed that medication compli-

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ance is generally overestimated in randomized clinical trials compared with the general population.[14] Data from the Prospective Registry Evaluating Myocardial Infarction: Event Recovery (PREMIER) Registry showed that only 86% of drug-eluting stent–treated MI patients discharged with thienopyridine medication continued taking the therapy after 30 days.[15] It is noteworthy that in the current study, the events detected at follow-up occurred despite more than 75% use of aspirin and clopidogrel and frequent use of β-blockers. In addition, the use or disuse of dual-antiplatelet therapy did not explain the increased risk of experiencing 1 of the composite end points or of stent thrombosis at either 6 or 12 months associated with off-label use of drug-eluting stents in EVENT.

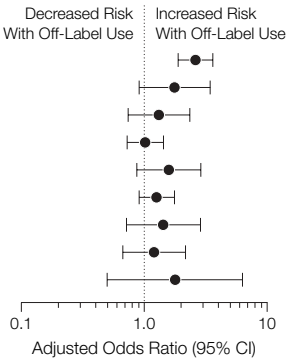
Implications

Although the current report presents only 12-month follow-up from 2 of the

Figure 3. Prediction by Off-Label Characteristics of the Primary Composite of Death, Myocardial Infarction, and Target Vessel Revascularization at Hospital Discharge and Death, Myocardial Infarction, Target Lesion Revascularization at Follow-up

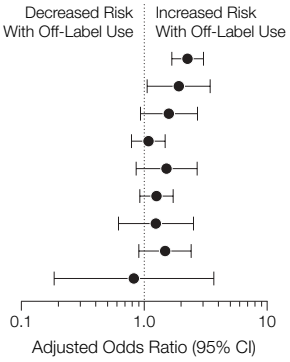
At Discharge From Index Admission

Criteria for Off-Label Use	Composite Outcome No./Total (%)	Adjusted Odds Ratio (95% CI)
Total Stent Length ≥36 mm	138/975 (14.2)	2.62 (1.89-3.61)
Ejection Fraction <25%	11/77 (14.3)	1.77 (0.91-3.44)
Baseline Creatine Kinase-MB >3 ULN	16/118 (13.6)	1.32 (0.74-2.34)
>1 Lesion Treated	123/1073 (11.5)	1.02 (0.73-1.44)
Stenosis Before Procedure, 100%	15/112 (13.4)	1.58 (0.87-2.89)
Bifurcation Lesion	50/473 (10.6)	1.27 (0.91-1.77)
Maximum Balloon Diameter >4 mm	10/76 (13.2)	1.44 (0.72-2.87)
Lesion in a Coronary Bypass Graft	14/173 (8.1)	1.20 (0.67-2.16)
Unprotected LM Intervention	3/20 (15)	1.78 (0.50-6.32)



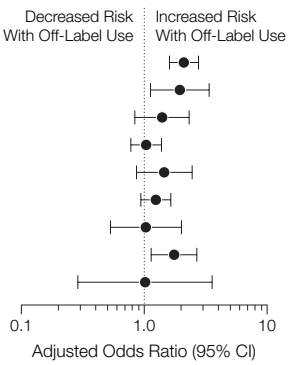
At 6 Months

Criteria for Off-Label Use	Composite Outcome No./Total (%)	Adjusted Odds Ratio (95% CI)
Total Stent Length ≥36 mm	162/923 (17.6)	2.25 (1.67-3.03)
Ejection Fraction <25%	15/75 (20.0)	1.91 (1.05-3.43)
Baseline Creatine Kinase-MB >3 ULN	20/109 (18.4)	1.58 (0.93-2.71)
>1 Lesion Treated	152/1021 (14.9)	1.08 (0.79-1.48)
Stenosis Before Procedure, 100%	17/101 (16.9)	1.52 (0.86-2.69)
Bifurcation Lesion	60/448 (13.4)	1.26 (0.92-1.71)
Maximum Balloon Diameter >4 mm	10/70 (14.3)	1.24 (0.61-2.05)
Lesion in a Coronary Bypass Graft	22/167 (13.2)	1.47 (0.90-2.41)
Unprotected LM Intervention	2/19 (10.6)	0.82 (0.18-3.67)



At 12 Months

Criteria for Off-Label Use	Composite Outcome No./Total (%)	Adjusted Odds Ratio (95% CI)
Total Stent Length ≥36 mm	193/954 (20.2)	2.11 (1.61-2.77)
Ejection Fraction <25%	18/75 (24)	1.95 (1.12-3.38)
Baseline Creatine Kinase-MB >3 ULN	22/113 (19.5)	1.39 (0.83-2.32)
>1 Lesion Treated	179/1046 (17.1)	1.04 (0.78-1.38)
Stenosis Before Procedure, 100%	21/108 (19.5)	1.46 (0.86-2.46)
Bifurcation Lesion	75/461 (16.2)	1.24 (0.94-1.65)
Maximum Balloon Diameter >4 mm	11/75 (14.7)	1.03 (0.53-2.01)
Lesion in a Coronary Bypass Graft	32/170 (18.8)	1.74 (1.14-2.68)
Unprotected LM Intervention	3/20 (15)	1.02 (0.28-3.58)



CI indicates confidence interval; LM, left main coronary artery; ULN, upper limit of normal.

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first 4 waves in EVENT, we believe that data from this period are critically important because they represent a cross-section of clinical practice at a crucial point in the development of drug-eluting stents. By the time enrollment in EVENT began, drug-eluting stent use had reached an early stage of maturity. Emerging intermediate-term follow-up of studies comparing bare-metal and drug-eluting stent implantation during this period has included signals of a hazard associated with drug-eluting stents use.[16,17] EVENT is not device specific and enrolls unselected patients. As such, it provides a valuable snapshot of the index stent implantations whose long-term outcomes are beginning to emerge in follow-up studies. The findings indicate a tendency to select relatively long stents, aggressive use of glycoprotein IIb/IIIa antagonists, and high use of aspirin and clopidogrel at 12 months, although the implementation of clopidogrel loading prior to PCI is probably suboptimal. The findings also indicate a relatively high rate of periprocedural MI despite these aggressive measures, and as in a report from the Evaluation of Platelet IIb/IIIa Inhibitor for Stenting (EPISTENT) trial by Cura et al,[18] most events in a stent population occurred in patients with angiographically complex lesions.

Limitations

These results should be interpreted with several caveats. First, by definition, registries do not include control groups. We therefore did not compare patients receiving drug-eluting stents off-label to concurrent patients receiving bare-metal stents for the same indications, nor did we compare them to patients undergoing coronary artery bypass graft surgery, perhaps a more appropriate comparator for some subgroups. Thus, the current observations do not allow differentiation of follow-up events resulting from more severe underlying disease in the off-label patients from those that are consequences of the stent implantation. Registries that have made this comparison have indicated favorable results for stenting[19] and several randomized comparisons are under way.[20,21] Second, although each reported stent thrombosis was adjudicated, the frequency of stent thrombosis was determined based on investigator observation rather than the recently developed Academic Research Consortium (ARC) definitions.[22] Third, the challenge of adjudicating periprocedural events in patients with elevated baseline CK or evolving acute coronary syndromes at the time of PCI has been recognized.[23] To improve specificity, the definition of post-PCI MI required a 3-fold increase in CK-MB levels for such patients.[7] Fourth, although the criteria defining the off-label group do not reflect verbatim the approved stent labels, they duplicate the criteria that excluded patients from inclusion in the trials used to support the currently approved labels for drug-eluting stents available in the United States. Finally, the current report consists of events observed up to one year and does not address the concerns of longer-term follow-up. In particular, several recent observations[24-26] suggest a persistently increased hazard of very late ischemic events when dual antiplatelet therapy is stopped 6 or 12 months after PCI. As a result, informal surveys suggest that the use of drug-eluting stents has declined slightly in recent months.[27] Whether this hazard is assumed primarily by high-risk (ie, off-label) or is also encountered by low risk (on-label) patients will need to be answered in longer-term follow-up.

CONCLUSIONS

Off-label use of drug-eluting stents is more common than on-label use and is associated with a persistently higher rate of adverse angiographic and clinical outcomes. In particular, stent thrombosis was observed predominantly in patients who underwent drug-eluting stents implantation for an off-label indication. Several specific off-label angiographic and clinical characteristics seemed to be associated with the highest incidence of adverse clinical events. Cinicians should be cautious about extrapolating the benefits of drug-eluting stents compared with bare-metal stents that were observed in randomized clinical trials to higher-risk clinical settings that have not been assessed. Whether drug-eluting stents should be used routinely in more complex patient subsets requires further study.

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2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention

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PRACTICE GUIDELINE

2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention

A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions

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Preamble

The medical profession should play a central role in evaluating the evidence related to drugs, devices, and procedures for the detection, management, and prevention of disease. When properly applied, expert analysis of available data on the benefits and risks of these therapies and procedures can improve the quality of care, optimize patient outcomes, and favorably affect costs by focusing resources on the most effective strategies. An organized and directed approach to a thorough review of evidence has resulted in the production of clinical practice guidelines that assist physicians in selecting the best management strategy for an individual patient. Moreover, clinical practice guidelines can provide a foundation for other applications, such as performance measures, appropriate use criteria, and both quality improvement and clinical decision support tools.

The American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) have jointly produced guidelines in the area of cardiovascular disease since 1980. The ACCF/AHA Task Force on Practice Guidelines (Task Force), charged with developing, updating, and revising practice guidelines for cardiovascular diseases and procedures, directs and oversees this effort. Writing committees are charged with regularly reviewing and evaluating all available evidence to develop balanced, patient-centric recommendations for clinical practice.

Experts in the subject under consideration are selected by the ACCF and AHA to examine subject-specific data and write guidelines in partnership with representatives from other medical organizations and specialty groups. Writing committees are asked to perform a formal literature review; weigh the strength of evidence for or against particular tests, treatments, or procedures; and include estimates of expected outcomes where such data exist. Patient-specific modifiers, comorbidities, and issues of patient preference that may influence the choice of tests or therapies are considered. When available, information from studies on cost is considered, but data on efficacy and outcomes constitute the primary basis for the recommendations contained herein.

In analyzing the data and developing recommendations and supporting text, the writing committee uses evidence-based methodologies developed by the Task Force (1). The Class of Recommendation (COR) is an estimate of the size of the treatment effect considering risks versus benefits in addition to evidence and/or agreement that a given treatment or procedure is or is not useful/effective or in some situations may cause harm. The Level of Evidence (LOE) is an estimate of the certainty or precision of the treatment effect. The writing committee reviews and ranks evidence supporting each recommendation with the weight of evidence ranked as LOE A, B, or C according to specific definitions that are included in Table 1. Studies are identified as observational, retrospective, prospective, or randomized where appropriate. For certain conditions for which inadequate data are available, recommendations are based on expert consensus and clinical experience and are ranked as LOE C. When recommendations at LOE C are supported by historical clinical data, appropriate references (including clinical reviews) are cited if available. For issues for which sparse data are available, a survey of current

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Table 1. Applying Classification of Recommendations and Level of Evidence

ESTIMATE OF CERTAINTY (PRECISION) OF TREATMENT EFFECT	CLASS I *Benefit >>> Risk* Procedure/Treatment **SHOULD** be performed/ administered	CLASS IIa *Benefit >> Risk* *Additional studies with focused objectives needed* **IT IS REASONABLE** to perform procedure/administer treatment	CLASS IIb *Benefit ≥ Risk* *Additional studies with broad objectives needed; additional registry data would be helpful* Procedure/Treatment **MAY BE CONSIDERED**	CLASS III *No Benefit* or CLASS III *Harm* Procedure/Test / Treatment COR III: No benefit — Not Helpful / No Proven Benefit COR III: Harm — Excess Cost w/o Benefit or Harmful / Harmful to Patients
LEVEL A Multiple populations evaluated* Data derived from multiple randomized clinical trials or meta-analyses	■ Recommendation that procedure or treatment is useful/effective ■ Sufficient evidence from multiple randomized trials or meta-analyses	■ Recommendation in favor of treatment or procedure being useful/effective ■ Some conflicting evidence from multiple randomized trials or meta-analyses	■ Recommendation's usefulness/efficacy less well established ■ Greater conflicting evidence from multiple randomized trials or meta-analyses	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Sufficient evidence from multiple randomized trials or meta-analyses
LEVEL B Limited populations evaluated* Data derived from a single randomized trial or nonrandomized studies	■ Recommendation that procedure or treatment is useful/effective ■ Evidence from single randomized trial or nonrandomized studies	■ Recommendation in favor of treatment or procedure being useful/effective ■ Some conflicting evidence from single randomized trial or nonrandomized studies	■ Recommendation's usefulness/efficacy less well established ■ Greater conflicting evidence from single randomized trial or nonrandomized studies	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Evidence from single randomized trial or nonrandomized studies
LEVEL C Very limited populations evaluated* Only consensus opinion of experts, case studies, or standard of care	■ Recommendation that procedure or treatment is useful/effective ■ Only expert opinion, case studies, or standard of care	■ Recommendation in favor of treatment or procedure being useful/effective ■ Only diverging expert opinion, case studies, or standard of care	■ Recommendation's usefulness/efficacy less well established ■ Only diverging expert opinion, case studies, or standard of care	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Only expert opinion, case studies, or standard of care
Suggested phrases for writing recommendations	should is recommended is indicated is useful/effective/beneficial	is reasonable can be useful/effective/beneficial is probably recommended or indicated	may/might be considered may/might be reasonable usefulness/effectiveness is unknown/unclear/uncertain or not well established	COR III: No Benefit: is not recommended; is not indicated; should not be performed/ administered/ other; is not useful/ beneficial/ effective COR III: Harm: potentially harmful; causes harm; associated with excess morbidity/mortality; should not be performed/ administered/ other
Comparative effectiveness phrases†	treatment/strategy A is recommended/indicated in preference to treatment B treatment A should be chosen over treatment B	treatment/strategy A is probably recommended/indicated in preference to treatment B it is reasonable to choose treatment A over treatment B		

A recommendation with Level of Evidence B or C does not imply that the recommendation is weak. Many important clinical questions addressed in the guidelines do not lend themselves to clinical trials. Although randomized trials are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

*Data available from clinical trials or registries about the usefulness/efficacy in different subpopulations, such as sex, age, history of diabetes, history of prior myocardial infarction, history of heart failure, and prior aspirin use. †For comparative effectiveness recommendations (Class I and IIa; Level of Evidence A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

practice among the clinicians on the writing committee is the basis for LOE C recommendations and no references are cited. The schema for COR and LOE is summarized in Table 1, which also provides suggested phrases for writing recommendations within each COR. A new addition to this methodology is separation of the Class III recommendations to delineate if the recommendation is determined to be of "no benefit" or is associated with "harm" to the patient. In addition, in view of the increasing number of comparative effectiveness studies, comparator verbs and suggested phrases for writing recommendations for the comparative effectiveness of one treatment or strategy versus another have been added for COR I and IIa, LOE A or B only.

In view of the advances in medical therapy across the spectrum of cardiovascular diseases, the Task Force has designated the term *guideline-directed medical therapy (GDMT)* to represent optimal medical therapy as defined by ACCF/AHA guideline recommended therapies (primarily Class I). This new term, GDMT, will be used herein and throughout all future guidelines.

Because the ACCF/AHA practice guidelines address patient populations (and healthcare providers) residing in North America, drugs that are not currently available in North America are discussed in the text without a specific COR. For studies performed in large numbers of subjects outside North America, each writing committee reviews the potential influence of different practice patterns and patient

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populations on the treatment effect and relevance to the ACCF/AHA target population to determine whether the findings should inform a specific recommendation.

The ACCF/AHA practice guidelines are intended to assist healthcare providers in clinical decision making by describing a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines attempt to define practices that meet the needs of most patients in most circumstances. The ultimate judgment regarding care of a particular patient must be made by the healthcare provider and patient in light of all the circumstances presented by that patient. As a result, situations may arise for which deviations from these guidelines may be appropriate. Clinical decision making should involve consideration of the quality and availability of expertise in the area where care is provided. When these guidelines are used as the basis for regulatory or payer decisions, the goal should be improvement in quality of care. The Task Force recognizes that situations arise in which additional data are needed to inform patient care more effectively; these areas will be identified within each respective guideline when appropriate.

Prescribed courses of treatment in accordance with these recommendations are effective only if followed. Because lack of patient understanding and adherence may adversely affect outcomes, physicians and other healthcare providers should make every effort to engage the patient's active participation in prescribed medical regimens and lifestyles. In addition, patients should be informed of the risks, benefits, and alternatives to a particular treatment and be involved in shared decision making whenever feasible, particularly for COR IIa and IIb, where the benefit-to-risk ratio may be lower.

The Task Force makes every effort to avoid actual, potential, or perceived conflicts of interest that may arise as a result of industry relationships or personal interests among the members of the writing committee. All writing committee members and peer reviewers of the guideline are asked to disclose all such current relationships, as well as those existing 12 months previously. In December 2009, the ACCF and AHA implemented a new policy for relationships with industry and other entities (RWI) that requires the writing committee chair plus a minimum of 50% of the writing committee to have no *relevant* RWI (Appendix 1 for the ACCF/AHA definition of relevance). These statements are reviewed by the Task Force and all members during each conference call and/or meeting of the writing committee and are updated as changes occur. All guideline recommendations require a confidential vote by the writing committee and must be approved by a consensus of the voting members. Members are not permitted to write, and must recuse themselves from voting on, any recommendation or section to which their RWI apply. Members who recused themselves from voting are indicated in the list of writing committee members, and section recusals are noted in Appendix 1. Authors' and peer reviewers' RWI pertinent to this guideline are disclosed in Appendixes 1 and 2, respectively. Additionally, to ensure complete transparency, writing committee members' comprehensive disclosure information—including RWI not pertinent to this document—is available as an online supplement. Comprehensive disclosure information for the Task Force is also available online at www.cardiosource.org/ACC/About-ACC/Leadership/Guidelines-and-Documents-Task-Forces.aspx. The work of the writing committee was supported exclusively by the ACCF, AHA, and the Society for Cardiovascular Angiography and Interventions (SCAI) without commercial support. Writing committee members volunteered their time for this activity.

In an effort to maintain relevance at the point of care for practicing physicians, the Task Force continues to oversee an ongoing process improvement initiative. As a result, in response to pilot projects, several changes to these guidelines will be apparent, including limited narrative text, a focus on summary and evidence tables (with references linked to abstracts in PubMed) and more liberal use of summary recommendation tables (with references that support LOE) to serve as a quick reference.

In April 2011, the Institute of Medicine released 2 reports: *Finding What Works in Health Care: Standards for Systematic Reviews* and *Clinical Practice Guidelines We Can Trust* (2,3). It is noteworthy that the ACCF/AHA guidelines were cited as being compliant with many of the standards that were proposed. A thorough review of these reports and of our current methodology is under way, with further enhancements anticipated.

The recommendations in this guideline are considered current until they are superseded by a focused update or the full-text guideline is revised. Guidelines are official policy of both the ACCF and AHA.

Alice K. Jacobs, MD, FACC, FAHA, Chair
ACCF/AHA Task Force on Practice Guidelines

1. Introduction

1.1. Methodology and Evidence Review

The recommendations listed in this document are, whenever possible, evidence based. An extensive evidence review was conducted through November 2010, as well as selected other references through August 2011. Searches were limited to studies, reviews, and other evidence conducted in human subjects and that were published in English. Key search words included but were not limited to the following: *ad hoc angioplasty*, *angioplasty*, *balloon angioplasty*, *clinical trial*, *coronary stenting*, *delayed angioplasty*, *meta-analysis*, *percutaneous transluminal coronary angioplasty*, *randomized controlled trial (RCT)*, *percutaneous coronary intervention (PCI) and angina*, *angina reduction*, *antiplatelet therapy*, *bare-metal stents (BMS)*, *cardiac rehabilitation*, *chronic stable angina*, *complication*, *coronary bifurcation lesion*, *coronary calcified lesion*, *coronary chronic total occlusion (CTO)*, *coronary ostial lesions*, *coronary stent (BMS and drug-eluting stents*

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[DES]; and BMS versus DES, *diabetes*, *distal embolization*, *distal protection*, *elderly*, *ethics*, *late stent thrombosis*, *medical therapy*, *microembolization*, *mortality*, *multiple lesions*, *multivessel*, *myocardial infarction (MI)*, *non–ST-elevation myocardial infarction (NSTEMI)*, *no-reflow*, *optical coherence tomography*, *proton pump inhibitor (PPI)*, *return to work*, *same-day angioplasty and/or stenting*, *slow flow*, *stable ischemic heart disease (SIHD)*, *staged angioplasty*, *STEMI*, *survival*, and *unstable angina (UA)*. Additional searches cross-referenced these topics with the following subtopics: *anticoagulant therapy*, *contrast nephropathy*, *PCI-related vascular complications*, *unprotected left main PCI*, *multivessel coronary artery disease (CAD)*, *adjunctive percutaneous interventional devices*, *percutaneous hemodynamic support devices*, and *secondary prevention*. Additionally, the committee reviewed documents related to the subject matter previously published by the ACCF and AHA. References selected and published in this document are representative and not all-inclusive.

To provide clinicians with a comprehensive set of data, whenever deemed appropriate or when published, the absolute risk difference and number needed to treat or harm will be provided in the guideline, along with confidence intervals (CIs) and data related to the relative treatment effects such as odds ratio (OR), relative risk, hazard ratio (HR), or incidence rate ratio.

The focus of this guideline is the safe, appropriate, and efficacious performance of PCI. The risks of PCI must be balanced against the likelihood of improved survival, symptoms, or functional status. This is especially important in patients with SIHD.

1.2. Organization of the Writing Committee

The committee was composed of physicians with expertise in interventional cardiology, general cardiology, critical care cardiology, cardiothoracic surgery, clinical trials, and health services research. The committee included representatives from the ACCF, AHA, and SCAI.

1.3. Document Review and Approval

This document was reviewed by 2 official reviewers nominated by the ACCF, AHA, and SCAI, as well as 21 individual content reviewers (including members of the ACCF Interventional Scientific Council and ACCF Surgeons' Scientific Council). All information on reviewers' RWI was distributed to the writing committee and is published in this document (Appendix 2). This document was approved for publication by the governing bodies of the ACCF, AHA, and SCAI.

1.4. PCI Guidelines: History and Evolution

In 1982, a 2-page manuscript titled "Guidelines for the Performance of Percutaneous Transluminal Coronary Angioplasty" was published in *Circulation* (4). The document, which addressed the specific expertise and experience physicians should have to perform balloon angioplasty, as well as laboratory requirements and the need for surgical support, was written by an ad hoc group whose members included Andreas Grüntzig. In 1980, the ACC and the AHA established the Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures, which was charged with the development of guidelines related to the role of new therapeutic approaches and of specific noninvasive and invasive procedures in the diagnosis and management of cardiovascular disease. The first ACC/AHA Task Force report on guidelines for coronary balloon angioplasty was published in 1988 (5). The 18-page document discussed and made recommendations about lesion classification and success rates, indications for and contraindications to balloon angioplasty, institutional review of angioplasty procedures, ad hoc angioplasty after angiography, and on-site surgical backup. Further iterations of the guidelines were published in 1993 (6), 2001 (7), and 2005 (8). In 2007 and 2009, focused updates to the guideline were published to expeditiously address new study results and recent changes in the field of interventional cardiology (9,10). The 2009 focused update is notable in that there was direct collaboration between the writing committees for the STEMI guidelines and the PCI guidelines, resulting in a single publication of focused updates on STEMI and PCI (10).

The evolution of the PCI guideline reflects the growth of knowledge in the field and parallels the many advances and innovations in the field of interventional cardiology, including primary PCI, BMS and DES, intravascular ultrasound (IVUS) and physiologic assessments of stenosis, and newer antiplatelet and anticoagulant therapies. The 2011 iteration of the guideline continues this process, addressing ethical aspects of PCI, vascular access considerations, CAD revascularization including hybrid revascularization, revascularization before noncardiac surgery, optical coherence tomography, advanced hemodynamic support devices, no-reflow therapies, and vascular closure devices. Most of this document is organized according to "patient flow," consisting of preprocedural considerations, procedural considerations, and postprocedural considerations. In a major undertaking, the STEMI, PCI, and coronary artery bypass graft (CABG) surgery guidelines were written concurrently, with additional collaboration with the SIHD guideline writing committee, allowing greater collaboration between the different writing committees on topics such as PCI in STEMI and revascularization strategies in patients with CAD (including unprotected left main PCI, multivessel disease revascularization, and hybrid procedures).

In accordance with direction from the Task Force and feedback from readers, in this iteration of the guideline, the text has been shortened, with an emphasis on summary statements rather than detailed discussion of numerous individual trials. Online supplemental evidence and summary tables have been created to document the

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studies and data considered for new or changed guideline recommendations.

2. CAD Revascularization

Recommendations and text in this section are the result of extensive collaborative discussions between the PCI and CABG writing committees, as well as key members of the SIHD and UA/NSTEMI writing committees. Certain issues, such as older versus more contemporary studies, primary analyses versus subgroup analyses, and prospective versus post hoc analyses, have been carefully weighed in designating COR and LOE; they are addressed in the appropriate corresponding text. The goals of revascularization for patients with CAD are to 1) improve survival and/or 2) relieve symptoms.

Revascularization recommendations in this section are predominantly based on studies of patients with symptomatic SIHD and should be interpreted in this context. As discussed later in this section, recommendations on the type of revascularization are, in general, applicable to patients with UA/NSTEMI. In some cases (e.g., unprotected left main CAD), specific recommendations are made for patients with UA/NSTEMI or STEMI.

Historically, most studies of revascularization have been based on and reported according to angiographic criteria. Most studies have defined a "significant" stenosis as ≥70% diameter narrowing; therefore, for revascularization decisions and recommendations in this section, a "significant" stenosis has been defined as ≥70% diameter narrowing (≥50% for left main CAD). Physiological criteria, such as an assessment of fractional flow reserve (FFR), has been used in deciding when revascularization is indicated. Thus, for recommendations about revascularization in this section, coronary stenoses with FFR ≤0.80 can also be considered to be "significant" (11,12).

As noted, the revascularization recommendations have been formulated to address issues related to 1) improved survival and/or 2) improved symptoms. When one method of revascularization is preferred over the other for improved survival, this consideration, in general, takes precedence over improved symptoms. When discussing options for revascularization with the patient, he or she should understand when the procedure is being performed in an attempt to improve symptoms, survival, or both.

Although some results from the SYNTAX (Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery) study are best characterized as subgroup analyses and "hypothesis generating," SYNTAX nonetheless represents the latest and most comprehensive comparison of PCI and CABG (13,14). Therefore, the results of SYNTAX have been considered appropriately when formulating our revascularization recommendations. Although the limitations of using the SYNTAX score for certain revascularization recommendations are recognized, the SYNTAX score is a reasonable surrogate for the extent of CAD and its complexity and serves as important information that should be considered when making revascularization decisions. Recommendations that refer to SYNTAX scores use them as surrogates for the extent and complexity of CAD.

Revascularization recommendations to improve survival and symptoms are provided in the following text and are summarized in Tables 2 and 3. References to studies comparing revascularization with medical therapy are presented when available for each anatomic subgroup.

See Online Data Supplements 1 and 2 for additional data regarding the survival and symptomatic benefits with CABG or PCI for different anatomic subsets.

2.1. Heart Team Approach to Revascularization Decisions: Recommendations

CLASS I

1. A Heart Team approach to revascularization is recommended in patients with unprotected left main or complex CAD (14–16). *(Level of Evidence: C)*

CLASS IIa

1. Calculation of the Society of Thoracic Surgeons (STS) and SYNTAX scores is reasonable in patients with unprotected left main and complex CAD (13,14,17–22). *(Level of Evidence: B)*

One protocol used in RCTs (14–16,23) often involves a multidisciplinary approach referred to as the Heart Team. Composed of an interventional cardiologist and a cardiac surgeon, the Heart Team 1) reviews the patient's medical condition and coronary anatomy, 2) determines that PCI and/or CABG are technically feasible and reasonable, and 3) discusses revascularization options with the patient before a treatment strategy is selected. Support for using a Heart Team approach comes from reports that patients with complex CAD referred specifically for PCI or CABG in concurrent trial registries have lower mortality rates than those randomly assigned to PCI or CABG in controlled trials (15,16).

The SIHD, PCI, and CABG guideline writing committees endorse a Heart Team approach in patients with unprotected left main CAD and/or complex CAD in whom the optimal revascularization strategy is not straightforward. A collaborative assessment of revascularization options, or the decision to treat with GDMT without revascularization, involving an interventional cardiologist, a cardiac surgeon, and (often) the patient's general cardiologist, followed by discussion with the patient about treatment options, is optimal. Particularly in patients with SIHD and unprotected left main and/or complex CAD for whom a revascularization strategy is not straightforward, an approach has been endorsed that involves terminating the procedure after diagnostic coronary angiography is completed: this allows a thorough discussion and affords both the interventional

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Table 2. Revascularization to Improve Survival Compared With Medical Therapy

Anatomic Setting	COR	LOE	References
UPLM or complex CAD			
CABG and PCI	I—Heart Team approach recommended	C	(14–16)
CABG and PCI	IIa—Calculation of STS and SYNTAX scores	B	(13,14,17–22)
UPLM*			
CABG	I	B	(24–30)
PCI	IIa—For SIHD when *both* of the following are present: • Anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX score of ≤22, ostial or trunk left main CAD) • Clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%)	B	(13,17,19,23,31–48)
	IIa—For UA/NSTEMI if not a CABG candidate	B	(13,36–39,44,45,47–49)
	IIa—For STEMI when distal coronary flow is TIMI flow grade <3 and PCI can be performed more rapidly and safely than CABG	C	(33,50,51)
	IIb—For SIHD when *both* of the following are present: • Anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low-intermediate SYNTAX score of <33, bifurcation left main CAD) • Clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate-severe COPD, disability from prior stroke, or prior cardiac surgery; STS-predicted risk of operative mortality >2%)	B	(13,17,19,23,31–48,52)
	III: Harm—For SIHD in patients (versus performing CABG) with unfavorable anatomy for PCI and who are good candidates for CABG	B	(13,17,19,24–32)
3-vessel disease with or without proximal LAD artery disease*			
CABG	I	B	(26,30 53–56)
	IIa—It is reasonable to choose CABG over PCI in patients with complex 3-vessel CAD (e.g., SYNTAX score >22) who are good candidates for CABG.	B	(32,46,56,71,72)
PCI	IIb—Of uncertain benefit	B	(26,46,53,56,82)
2-vessel disease with proximal LAD artery disease*			
CABG	I	B	(26,30,53–56)
PCI	IIb—Of uncertain benefit	B	(26,53,56,82)
2-vessel disease without proximal LAD artery disease*			
CABG	IIa—With extensive ischemia	B	(60–63)
	IIb—Of uncertain benefit without extensive ischemia	C	(56)
PCI	IIb—Of uncertain benefit	B	(26,53,56,82)
1-vessel proximal LAD artery disease			
CABG	IIa—With LIMA for long-term benefit	B	(30,56,69,70)
PCI	IIb—Of uncertain benefit	B	(26,53,56,82)
1-vessel disease without proximal LAD artery involvement			
CABG	III: Harm	B	(30,53,60,61,94–98)
PCI	III: Harm	B	(30,53,60,61,94–98)
LV dysfunction			
CABG	IIa—EF 35% to 50%	B	(30,64–68)
CABG	IIb—EF <35% without significant left main CAD	B	(30,64–68,83,84)
PCI	Insufficient data		N/A
Survivors of sudden cardiac death with presumed ischemia-mediated VT			
CABG	I	B	(57–59)
PCI	I	C	(57)
No anatomic or physiologic criteria for revascularization			
CABG	III: Harm	B	(30,53,60,61,94–98)
PCI	III: Harm	B	(30,53,60,61,94–98)

***In patients with multivessel disease who also have diabetes, it is reasonable to choose CABG (with LIMA) over PCI (62,74–81) (*Class IIa; LOE: B*).**

CABG indicates coronary artery bypass graft; CAD, coronary artery disease; COPD, chronic obstructive pulmonary disease; COR, class of recommendation; EF, ejection fraction; LAD, left anterior descending; LIMA, left internal mammary artery; LOE, level of evidence; LV, left ventricular; N/A, not applicable; PCI, percutaneous coronary intervention; SIHD, stable ischemic heart disease; STEMI, ST-elevation myocardial infarction; STS, Society of Thoracic Surgeons; SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery; TIMI, Thrombolysis In Myocardial Infarction; UA/NSTEMI, unstable angina/non–ST-elevation myocardial infarction; UPLM, unprotected left main disease; and VT, ventricular tachycardia.

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Table 3. Revascularization to Improve Symptoms With Significant Anatomic (≥50% Left Main or ≥70% Non–Left Main CAD) or Physiological (FFR≤0.80) Coronary Artery Stenoses

Clinical Setting	COR	LOE	References
≥1 significant stenoses amenable to revascularization and unacceptable angina despite GDMT	I—CABG I—PCI	A	(82,99–108)
≥1 significant stenoses and unacceptable angina in whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences	IIa—CABG IIa—PCI	C	N/A
Previous CABG with ≥1 significant stenoses associated with ischemia and unacceptable angina despite GDMT	IIa—PCI	C	(86,89,92)
	IIb—CABG	C	(93)
Complex 3-vessel CAD (e.g., SYNTAX score >22) with or without involvement of the proximal LAD artery and a good candidate for CABG	IIa—CABG preferred over PCI	B	(32,46,56,71,72)
Viable ischemic myocardium that is perfused by coronary arteries that are not amenable to grafting	IIb—TMR as an adjunct to CABG	B	(109–113)
No anatomic or physiologic criteria for revascularization	III: Harm—CABG III: Harm—PCI	C	N/A

CABG indicates coronary artery bypass graft; CAD, coronary artery disease; COR, class of recommendation; FFR, fractional flow reserve; GDMT, guideline-directed medical therapy; LOE, level of evidence; N/A, not applicable; PCI, percutaneous coronary intervention; SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery; and TMR, transmyocardial laser revascularization.

cardiologist and cardiac surgeon the opportunity to discuss revascularization options with the patient. Because the STS score and the SYNTAX score have been shown to predict adverse outcomes in patients undergoing CABG and PCI, respectively, calculation of these scores is often useful in making revascularization decisions (13,14,17–22).

2.2. Revascularization to Improve Survival: Recommendations

Left Main CAD Revascularization

CLASS I

1. CABG to improve survival is recommended for patients with significant (≥50% diameter stenosis) left main coronary artery stenosis (24–30). *(Level of Evidence: B)*

CLASS IIa

1. PCI to improve survival is reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX score [≤22], ostial or trunk left main CAD); and 2) clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%) (13,17,19,23,31–48). *(Level of Evidence: B)*
2. PCI to improve survival is reasonable in patients with UA/NSTEMI when an unprotected left main coronary artery is the culprit lesion and the patient is not a candidate for CABG (13,36–39,44,45,47–49). *(Level of Evidence: B)*
3. PCI to improve survival is reasonable in patients with acute STEMI when an unprotected left main coronary artery is the culprit lesion, distal coronary flow is less than TIMI (Thrombolysis In Myocardial Infarction) grade 3, and PCI can be performed more rapidly and safely than CABG (33,50,51). *(Level of Evidence: C)*

CLASS IIb

1. PCI to improve survival may be reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low-intermediate SYNTAX score of <33, bifurcation left main CAD); and 2) clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate-severe chronic obstructive pulmonary disease, disability from previous stroke, or previous cardiac surgery; STS-predicted risk of operative mortality >2%) (13,17,19,23,31–48,52). *(Level of Evidence: B)*

CLASS III: HARM

1. PCI to improve survival should not be performed in stable patients with significant (≥50% diameter stenosis) unprotected left main CAD who have unfavorable anatomy for PCI and who are good candidates for CABG (13,17,19,24–32). *(Level of Evidence: B)*

Non–Left Main CAD Revascularization

CLASS I

1. CABG to improve survival is beneficial in patients with significant (≥70% diameter) stenoses in 3 major coronary arteries (with or without involvement of the proximal left anterior descending [LAD] artery) or in the proximal LAD plus 1 other major coronary artery (26,30,53–56). *(Level of Evidence: B)*
2. CABG or PCI to improve survival is beneficial in survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia caused by significant (≥70% diameter) stenosis in a major coronary artery. *(CABG Level of Evidence: B* [57–59]*; PCI Level of Evidence: C* [57]*)*

CLASS IIa

1. CABG to improve survival is reasonable in patients with significant (≥70% diameter) stenoses in 2 major coronary arteries with severe or extensive myocardial ischemia (e.g., high-risk criteria on stress testing, abnormal intracoronary hemodynamic evaluation, or >20% perfusion defect by myocardial perfusion stress imaging) or target vessels supplying a large area of viable myocardium (60–63). *(Level of Evidence: B)*
2. CABG to improve survival is reasonable in patients with mild-moderate left ventricular (LV) systolic dysfunction (ejection fraction [EF] 35% to 50%) and significant (≥70% diameter stenosis) multivessel CAD or proximal LAD coronary artery stenosis, when viable myocardium is present in the region of intended revascularization (30,64–68). *(Level of Evidence: B)*

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3. CABG with a left internal mammary artery (LIMA) graft to improve survival is reasonable in patients with significant (≥70% diameter) stenosis in the proximal LAD artery and evidence of extensive ischemia (30,56,69,70). *(Level of Evidence: B)*
4. It is reasonable to choose CABG over PCI to improve survival in patients with complex 3-vessel CAD (e.g., SYNTAX score >22), with or without involvement of the proximal LAD artery who are good candidates for CABG (32,46,56,71,72). *(Level of Evidence: B)*
5. CABG is probably recommended in preference to PCI to improve survival in patients with multivessel CAD and diabetes mellitus, particularly if a LIMA graft can be anastomosed to the LAD artery (62,74–81). *(Level of Evidence: B)*

CLASS IIb

1. The usefulness of CABG to improve survival is uncertain in patients with significant (≥70%) diameter stenoses in 2 major coronary arteries not involving the proximal LAD artery and without extensive ischemia (56). *(Level of Evidence: C)*
2. The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease (26,53,56,82). *(Level of Evidence: B)*
3. CABG might be considered with the primary or sole intent of improving survival in patients with SIHD with severe LV systolic dysfunction (EF <35%) whether or not viable myocardium is present (30,64–68,83,84). *(Level of Evidence: B)*
4. The usefulness of CABG or PCI to improve survival is uncertain in patients with previous CABG and extensive anterior wall ischemia on noninvasive testing (85–93). *(Level of Evidence: B)*

CLASS III: HARM

1. CABG or PCI should not be performed with the primary or sole intent to improve survival in patients with SIHD with 1 or more coronary stenoses that are not anatomically or functionally significant (e.g., <70% diameter non–left main coronary artery stenosis, FFR >0.80, no or only mild ischemia on noninvasive testing), involve only the left circumflex or right coronary artery, or subtend only a small area of viable myocardium (30,53,60,61,94–98). *(Level of Evidence: B)*

2.3. Revascularization to Improve Symptoms: Recommendations

CLASS I

1. CABG or PCI to improve symptoms is beneficial in patients with 1 or more significant (≥70% diameter) coronary artery stenoses amenable to revascularization and unacceptable angina despite GDMT (82,99–108). *(Level of Evidence: A)*

CLASS IIa

1. CABG or PCI to improve symptoms is reasonable in patients with 1 or more significant (≥70% diameter) coronary artery stenoses and unacceptable angina for whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences. *(Level of Evidence: C)*
2. PCI to improve symptoms is reasonable in patients with previous CABG, 1 or more significant (≥70% diameter) coronary artery stenoses associated with ischemia, and unacceptable angina despite GDMT (86,89,92). *(Level of Evidence: C)*
3. It is reasonable to choose CABG over PCI to improve symptoms in patients with complex 3-vessel CAD (e.g., SYNTAX score >22), with or without involvement of the proximal LAD artery who are good candidates for CABG (32,46,56,72,73). *(Level of Evidence: B)*

CLASS IIb

1. CABG to improve symptoms might be reasonable for patients with previous CABG, 1 or more significant (≥70% diameter) coronary artery stenoses not amenable to PCI, and unacceptable angina despite GDMT (93). *(Level of Evidence: C)*
2. Transmyocardial laser revascularization (TMR) performed as an adjunct to CABG to improve symptoms may be reasonable in patients with viable ischemic myocardium that is perfused by arteries that are not amenable to grafting (109–113). *(Level of Evidence: B)*

CLASS III: HARM

1. CABG or PCI to improve symptoms should not be performed in patients who do not meet anatomic (≥50% diameter left main or ≥70% non–left main stenosis diameter) or physiological (e.g., abnormal FFR) criteria for revascularization. *(Level of Evidence: C)*

2.4. CABG Versus Contemporaneous Medical Therapy

In the 1970s and 1980s, 3 RCTs established the survival benefit of CABG compared with contemporaneous (although minimal by current standards) medical therapy without revascularization in certain subjects with stable angina: the Veterans Affairs Cooperative Study (114), European Coronary Surgery Study (55), and CASS (Coronary Artery Surgery Study) (115). Subsequently, a 1994 meta-analysis of 7 studies that randomized a total of 2,649 patients to medical therapy or CABG (30) showed that CABG offered a survival advantage over medical therapy for patients with left main or 3-vessel CAD. The studies also established that CABG is more effective than medical therapy for relieving anginal symptoms. These studies have been replicated only once during the past decade. In MASS II (Medicine, Angioplasty, or Surgery Study II), patients with multivessel CAD who were treated with CABG were less likely than those treated with medical therapy to have a subsequent MI, need additional revascularization, or experience cardiac death in the 10 years after randomization (104).

Surgical techniques and medical therapy have improved substantially during the intervening years. As a result, if CABG were to be compared with GDMT in RCTs today, the relative benefits for survival and angina relief observed several decades ago might no longer be observed. Conversely, the concurrent administration of GDMT may substantially improve long-term outcomes in patients treated with CABG in comparison with those receiving medical therapy alone. In the BARI 2D (Bypass Angioplasty Revascularization Investigation 2 Diabetes) trial of patients with diabetes mellitus, no significant difference in risk of mortality in the cohort of patients randomized to GDMT plus CABG or GDMT alone was observed, although the study was not powered for this endpoint, excluded patients with significant left main CAD, and included only a small percentage of patients with proximal

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LAD artery disease or LV ejection fraction (LVEF) <0.50 (116). The PCI and CABG guideline writing committees endorse the performance of the ISCHEMIA (International Study of Comparative Health Effectiveness with Medical and Invasive Approaches) trial, which will provide contemporary data on the optimal management strategy (medical therapy or revascularization with CABG or PCI) of patients with SIHD, including multivessel CAD, and moderate to severe ischemia.

2.5. PCI Versus Medical Therapy

Although contemporary interventional treatments have lowered the risk of restenosis compared with earlier techniques, meta-analyses have failed to show that the introduction of BMS confers a survival advantage over balloon angioplasty (117–119) or that the use of DES confers a survival advantage over BMS (119,120).

No study to date has demonstrated that PCI in patients with SIHD improves survival rates (26,53,56,82,116,119,121–124). Neither COURAGE (Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation) (82) nor BARI 2D (116), which treated all patients with contemporary optimal medical therapy, demonstrated any survival advantage with PCI, although these trials were not specifically powered for this endpoint. Although 1 large analysis evaluating 17 RCTs of PCI versus medical therapy (including 5 trials of subjects with acute coronary syndromes [ACS]) found a 20% reduction in death with PCI compared with medical therapy (123), 2 other large analyses did not (119,122). An evaluation of 13 studies reporting the data from 5,442 patients with nonacute CAD showed no advantage of PCI over medical therapy for the individual endpoints of all-cause death, cardiac death or MI, or nonfatal MI (124). Evaluation of 61 trials of PCI conducted over several decades shows that despite improvements in PCI technology and pharmacotherapy, PCI has not been demonstrated to reduce the risk of death or MI in patients without recent ACS (119).

The findings from individual studies and systematic reviews of PCI versus medical therapy can be summarized as follows:

- PCI reduces the incidence of angina (82,99,104,107,108,125).
- PCI has not been demonstrated to improve survival in stable patients (119,121,122).
- PCI may increase the short-term risk of MI (82,121,125,126).
- PCI does not lower the long-term risk of MI (82,116,119,121,122,126).

2.6. CABG Versus PCI

The results of 26 RCTs comparing CABG and PCI have been published: Of these, 9 compared CABG with balloon angioplasty (75,105,128–142), 14 compared CABG with BMS implantation (88,143–160), and 3 compared CABG with DES implantation (14,161,162).

2.6.1. CABG Versus Balloon Angioplasty or BMS

A systematic review of the 22 RCTs comparing CABG with balloon angioplasty or BMS implantation concluded the following (163):

1. Survival was similar for CABG and PCI (with balloon angioplasty or BMS) at 1 year and 5 years. Survival was similar for CABG and PCI in subjects with 1-vessel CAD (including those with disease of the proximal portion of the LAD artery) or multivessel CAD.
2. Incidence of MI was similar at 5 years after randomization.
3. Procedural stroke occurred more commonly with CABG than with PCI (1.2% versus 0.6%).
4. Relief of angina was accomplished more effectively with CABG than with PCI 1 year after randomization and 5 years after randomization.
5. During the first year after randomization, repeat coronary revascularization was performed less often after CABG than after PCI (3.8% versus 26.5%). This was also demonstrated after 5 years of follow-up (9.8% versus 46.1%). This difference was more pronounced with balloon angioplasty than with BMS.

A collaborative analysis of data from 10 RCTs comparing CABG with balloon angioplasty (6 trials) or with BMS implantation (4 trials) (164) permitted subgroup analyses of the data from the 7,812 patients. No difference was noted with regard to mortality rate 5.9 years after randomization or the composite endpoint of death or MI. Repeat revascularization and angina were noted more frequently in those treated with balloon angioplasty or BMS implantation (164). The major new observation of this analysis was that CABG was associated with better outcomes in patients with diabetes mellitus and in those >65 years old. Of interest, the relative outcomes of CABG and PCI were not influenced by other patient characteristics, including the number of diseased coronary arteries.

The aforementioned meta-analysis and systematic review (163,164) comparing CABG and balloon angioplasty or BMS implantation were limited in several ways:

1. Many trials did not report outcomes for other important patient subsets. For example, the available data are insufficient to determine if race, obesity, renal dysfunction, peripheral arterial disease, or previous coronary revascularization affected the comparative outcomes of CABG and PCI.
2. Most of the patients enrolled in these trials were male, and most had 1- or 2-vessel CAD and normal LV systolic function (EF >50%)—subjects known to be unlikely to derive a survival benefit and less likely to experience complications after CABG (30).
3. The patients enrolled in these trials represented only a small fraction (generally <5% to 10%) of those who were screened. For example, most screened patients with

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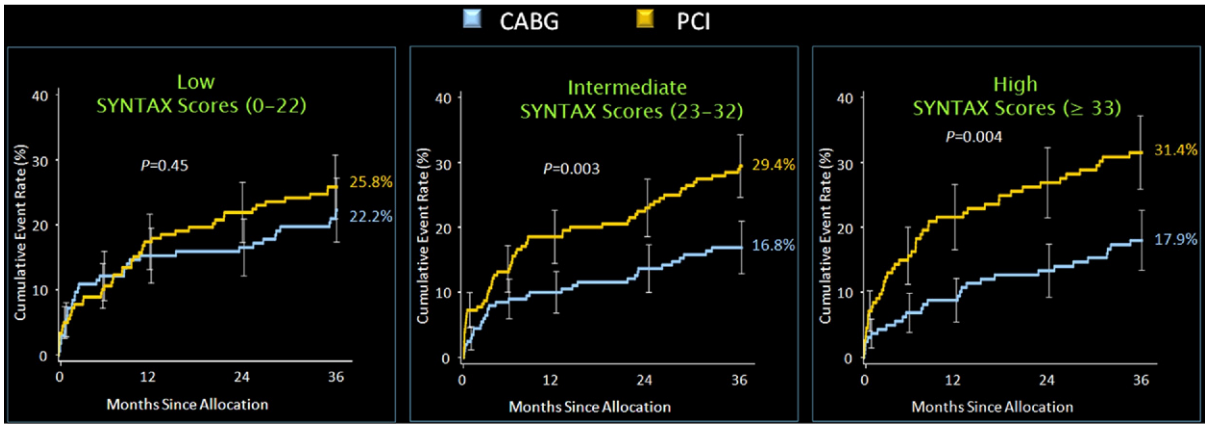

Figure 1. Cumulative Incidence of MACE in Patients With 3-Vessel CAD Based on SYNTAX Score at 3-Year Follow-Up in the SYNTAX Trial Treated With Either CABG or PCI

CABG indicates coronary artery bypass graft; CAD, coronary artery disease; MACE, major adverse cardiovascular event; PCI, percutaneous coronary intervention; and SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery. Adapted with permission from Kappetein (46).

1-vessel CAD and many with 3-vessel CAD were not considered for randomization.

See Online Data Supplements 3 and 4 for additional data comparing CABG with PCI.

2.6.2. CABG Versus DES

Although the results of 9 observational studies comparing CABG and DES implantation have been published (32,165–172), most of them had short (12 to 24 months) follow-up periods. In a meta-analysis of 24,268 patients with multivessel CAD treated with CABG or DES (173), the incidences of death and MI were similar for the 2 procedures, but the frequency with which repeat revascularization was performed was roughly 4 times higher after DES implantation. Only 1 large RCT comparing CABG and DES implantation has been published. The SYNTAX trial randomly assigned 1,800 patients (of a total of 4,337 who were screened) to receive DES or CABG (14,46). Major adverse cardiac events (MACE), a composite of death, stroke, MI, or repeat revascularization during the 3 years after randomization, occurred in 20.2% of CABG patients and 28.0% of those undergoing DES implantation ($p<0.001$). The rates of death and stroke were similar; however, MI (3.6% for CABG, 7.1% for DES) and repeat revascularization (10.7% for CABG, 19.7% for DES) were more likely to occur with DES implantation (46).

In SYNTAX, the extent of CAD was assessed using the SYNTAX score, which is based on the location, severity, and extent of coronary stenoses, with a low score indicating less complicated anatomic CAD. In post hoc analyses, a low score was defined as ≤22; intermediate, 23 to 32; and high, ≥33. The occurrence of MACE correlated with the SYNTAX score for DES patients but not for those undergoing CABG. At 12-month follow-up, the primary endpoint was similar for CABG and DES in those with a low SYNTAX score. In contrast, MACE occurred more often after DES implantation than after CABG in those with an intermediate or high SYNTAX score (14). At 3 years of follow-up, the mortality rate was greater in subjects with 3-vessel CAD treated with PCI than in those treated with CABG (6.2% versus 2.9%). The differences in MACE between those treated with PCI or CABG increased with an increasing SYNTAX score (Figure 1) (46).

Although the utility of using a SYNTAX score in everyday clinical practice remains uncertain, it seems reasonable to conclude from SYNTAX and other data that outcomes of patients undergoing PCI or CABG in those with relatively uncomplicated and lesser degrees of CAD are comparable, whereas in those with complex and diffuse CAD, CABG appears to be preferable (46).

See Online Data Supplements 5 and 6 for additional data comparing CABG with DES.

2.7. Left Main CAD

2.7.1. CABG or PCI Versus Medical Therapy for Left Main CAD

CABG confers a survival benefit over medical therapy in patients with left main CAD. Subgroup analyses from RCTs performed 3 decades ago included 91 patients with left main CAD in the Veterans Administration Cooperative Study (28). A meta-analysis of these trials demonstrated a 66% reduction in relative risk in mortality with CABG, with the benefit extending to 10 years (30). The CASS Registry (24) contained data from 1,484 patients with ≥50% diameter stenosis left main CAD initially treated surgically or nonsurgically. Median survival duration was 13.3 years in the surgical group; and 6.6 years in the medical group. The survival benefit of CABG over medical therapy appeared to extend to 53 asymptomatic patients with left main CAD in the CASS Registry (29). Other therapies that subsequently have been shown to be associated with improved long-term outcome, such as the use of aspirin, statins, and internal mammary artery grafting, were not widely used in that era.

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RCTs and subgroup analyses that compare PCI with medical therapy in patients with "unprotected" left main CAD do not exist.

2.7.2. Studies Comparing PCI Versus CABG for Left Main CAD

Of all subjects undergoing coronary angiography, approximately 4% are found to have left main CAD (175), >80% of whom have significant (≥70% diameter) stenoses in other epicardial coronary arteries.

Published cohort studies have found that major clinical outcomes are similar with PCI or CABG 1 year after revascularization and that mortality rates are similar at 1, 2, and 5 years of follow-up; however, the risk of needing target-vessel revascularization is significantly higher with stenting than with CABG.

In the SYNTAX trial, 45% of screened patients with unprotected left main CAD had complex disease that prevented randomization; 89% of these underwent CABG (13,14). In addition, 705 of the 1,800 patients who were randomized had revascularization for unprotected left main CAD. The majority of patients with left main CAD and a low SYNTAX score had isolated left main CAD or left main CAD plus 1-vessel CAD; the majority of those with an intermediate score had left main CAD plus 2-vessel CAD; and most of those with a high SYNTAX score had left main CAD plus 3-vessel CAD. At 1 year, rates of all-cause death and MACE were similar for the 2 groups (13). Repeat revascularization rates were higher in the PCI group than the CABG group (11.8% versus 6.5%), but stroke occurred more often in the CABG group (2.7% versus 0.3%). At 3 years of follow-up, the incidence of death in those undergoing left main CAD revascularization with low or intermediate SYNTAX scores (≤32) was 3.7% after PCI and 9.1% after CABG (p=0.03), whereas in those with a high SYNTAX score (≥33), the incidence of death after 3 years was 13.4% after PCI and 7.6% after CABG (p=0.10) (46). Because the primary endpoint of SYNTAX was not met (i.e., noninferiority comparison of CABG and PCI), these subgroup analyses need to be considered in that context.

In the LE MANS (Study of Unprotected Left Main Stenting Versus Bypass Surgery) trial (23), 105 patients with left main CAD were randomized to receive PCI or CABG. Although a low proportion of patients treated with PCI received DES (35%) and a low proportion of patients treated with CABG received internal mammary grafts (72%), the outcomes at 30 days and 1 year were similar between the groups. In the PRECOMBAT (Premier of Randomized Comparison of Bypass Surgery versus Angioplasty Using Sirolimus-Eluting Stent in Patients with Left Main Coronary Artery Disease) trial of 600 patients with left main disease, the composite endpoint of death, MI, or stroke at 2 years occurred in 4.4% of patients treated with PCI patients and 4.7% of patients treated with CABG, but ischemia-driven target-vessel revascularization was more often required in the patients treated with PCI (9.0% versus 4.2%) (52).

The results from these 3 RCTs suggest (but do not definitively prove) that major clinical outcomes in *selected* patients with left main CAD are similar with CABG and PCI at 1- to 2-year follow-up, but repeat revascularization rates are higher after PCI than after CABG. RCTs with extended follow-up of ≥5 years are required to provide definitive conclusions about the optimal treatment of left main CAD. In a meta-analysis of 8 cohort studies and 2 RCTs (41), death, MI, and stroke occurred with similar frequency in the PCI- and CABG-treated patients at 1, 2, and 3 years of follow-up. Target-vessel revascularization was performed more often in the PCI group at 1 year (OR: 4.36), 2 years (OR: 4.20), and 3 years (OR: 3.30).

See Online Data Supplements 7 to 12 for additional data comparing PCI with CABG for left main CAD.

2.7.3. Revascularization Considerations for Left Main CAD

Although CABG has been considered the "gold standard" for unprotected left main CAD revascularization, more recently PCI has emerged as a possible alternative mode of revascularization in carefully selected patients. Lesion location is an important determinant when considering PCI for unprotected left main CAD. Stenting of the left main ostium or trunk is more straightforward than treating distal bifurcation or trifurcation stenoses, which generally requires a greater degree of operator experience and expertise (176). In addition, PCI of bifurcation disease is associated with higher restenosis rates than when disease is confined to the ostium or trunk (39,177). Although lesion location influences technical success and long-term outcomes after PCI, location exerts a negligible influence on the success of CABG. In subgroup analyses, patients with left main CAD and a SYNTAX score ≥33 with more complex or extensive CAD had a higher mortality rate with PCI than with CABG (46). Physicians can estimate operative risk for all CABG candidates using a standard instrument, such as the risk calculator from the STS database. The above considerations are important factors when choosing among revascularization strategies for unprotected left main CAD and have been factored into revascularization recommendations. Use of a Heart Team approach has been recommended in cases in which the choice of revascularization is not straightforward. As discussed in Section 2.9.7, the ability of the patient to tolerate and comply with dual antiplatelet therapy (DAPT) is also an important consideration in revascularization decisions.

The 2005 PCI guideline (8) recommended routine angiographic follow-up 2 to 6 months after stenting for unprotected left main CAD. However, because angiography has limited ability to predict stent thrombosis and the results of SYNTAX suggest good intermediate-term results for PCI in subjects with left main CAD, this recommen-

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dation was removed in the 2009 STEMI/PCI focused update (10).

Experts have recommended immediate PCI for unprotected left main CAD in the setting of STEMI (51). The impetus for such a strategy is greatest when left main CAD is the site of the culprit lesion, antegrade coronary flow is diminished (e.g., TIMI flow grade 0, 1, or 2), the patient is hemodynamically unstable, and it is believed that PCI can be performed more quickly than CABG. When possible, the interventional cardiologist and cardiac surgeon should decide together on the optimal form of revascularization for these subjects, although it is recognized that these patients are usually critically ill and therefore not amenable to a prolonged deliberation or discussion of treatment options.

2.8. Proximal LAD Artery Disease

A cohort study (53) and a meta-analysis (30) from the 1990s suggested that CABG confers a survival advantage over contemporaneous medical therapy for patients with disease in the proximal segment of the LAD artery. Cohort studies and RCTs (30,133,146,148,161,178–181) as well as collaborative- and meta-analyses (164,182–184) showed that PCI and CABG result in similar survival rates in these patients.

See Online Data Supplement 13 for additional data regarding proximal LAD artery revascularization.

2.9. Clinical Factors That May Influence the Choice of Revascularization

2.9.1. Diabetes Mellitus

An analysis performed in 2009 of data on 7,812 patients (1,233 with diabetes) in 10 RCTs demonstrated a worse long-term survival rate in patients with diabetes mellitus after balloon angioplasty or BMS implantation than after CABG (164). The BARI 2D trial (116) randomly assigned 2,368 patients with type 2 diabetes and CAD to undergo intensive medical therapy or prompt revascularization with PCI or CABG, according to whichever was thought to be more appropriate. By study design, those with less extensive CAD more often received PCI, whereas those with more extensive CAD were more likely to be treated with CABG. The study was not designed to compare PCI with CABG. At 5-year follow-up, no difference in rates of survival or MACE between the medical therapy group and those treated with revascularization was noted. In the PCI stratum, no significant difference in MACE between medical therapy and revascularization was demonstrated (DES in 35%; BMS in 56%); in the CABG stratum, MACE occurred less often in the revascularization group. One-year follow-up data from the SYNTAX study demonstrated a higher rate of repeat revascularization in patients with diabetes mellitus treated with PCI than with CABG, driven by a tendency for higher repeat revascularization rates in those with higher SYNTAX scores undergoing PCI (76). In summary, in subjects requiring revascularization for multivessel CAD, current evidence supports diabetes mellitus as an important factor when deciding on a revascularization strategy, particularly when complex or extensive CAD is present (Figure 2).

See Online Data Supplements 14 and 15 for additional data regarding diabetes mellitus.

2.9.2. Chronic Kidney Disease

Cardiovascular morbidity and mortality rates are markedly increased in patients with chronic kidney disease (CKD) when compared with age-matched controls without CKD. The mortality rate for patients on hemodialysis is >20% per year, and approximately 50% of deaths among these patients are due to a cardiovascular cause (187,188).

To date, randomized comparisons of coronary revascularization (with CABG or PCI) and medical therapy in patients with CKD have not been reported. Some, but not all, observational studies or subgroup analyses have demonstrated an improved survival rate with revascularization compared with medical therapy in patients with CKD and multivessel CAD (189–191), despite the fact that the incidence of periprocedural complications (e.g., death, MI, stroke, infection, renal failure) is increased in patients with CKD compared with those without renal dysfunction. Some studies have shown that CABG is associated with a greater survival benefit than PCI among patients with severe renal dysfunction (190–196).

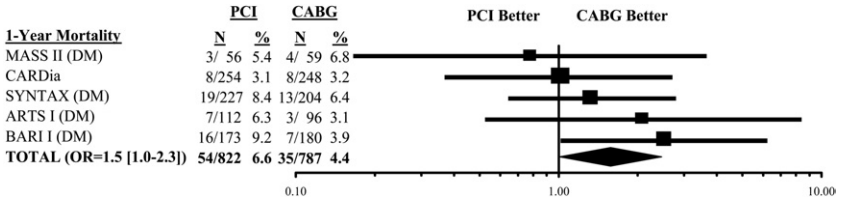

Figure 2. 1-Year Mortality After Revascularization for Multivessel Disease and Diabetes Mellitus

An OR of >1 suggests an advantage of CABG over PCI. ARTS I indicates Arterial Revascularization Therapy Study I (185); BARI I, Bypass Angioplasty Revascularization Investigation I (74); CABG, coronary artery bypass graft; CAD, coronary artery disease; CARDia, Coronary Artery Revascularization in Diabetes (186); CI, confidence interval; MASS II, Medicine, Angioplasty, or Surgery Study II (78); OR, odds ratio; PCI, percutaneous coronary intervention; SYNTAX, Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery; and W, weighted (76).

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2.9.3. Completeness of Revascularization

Most patients undergoing CABG receive complete or nearly complete revascularization, which seems to influence long-term prognosis positively (197). In contrast, complete revascularization is accomplished less often in subjects receiving PCI (e.g., in <70% of patients), but the extent to which the absence of complete initial revascularization influences outcome is less clear. Rates of late survival and survival free of MI appears to be similar in patients with and without complete revascularization after PCI. Nevertheless, the need for subsequent CABG is usually higher in those whose initial revascularization procedure was incomplete (compared with those with complete revascularization) after PCI (198–200).

2.9.4. LV Systolic Dysfunction

Several older studies and a meta-analysis of the data from these studies reported that patients with LV systolic dysfunction (predominantly mild to moderate in severity) had better survival with CABG than with medical therapy alone (30,64–68). For patients with more severe LV systolic dysfunction, however, the evidence that CABG results in better survival compared with medical therapy is lacking. In the STICH (Surgical Treatment for Ischemic Heart Failure) trial of subjects with LVEF <35% with or without viability testing, CABG and GDMT resulted in similar rates of survival (death from any cause, the study's primary outcome) after 5 years of follow-up. For a number of secondary outcomes at this time point, including 1) death from any cause or hospitalization for heart failure, 2) death from any cause or hospitalization for cardiovascular causes, 3) death from any cause or hospitalization for any cause, or 4) death from any cause or revascularization with PCI or CABG, CABG was superior to GDMT. Although the primary outcome (death from any cause) was similar in the 2 treatment groups after an average of 5 years of follow-up, the data suggest the possibility that outcomes would differ if the follow-up were longer in duration; as a result, the study is being continued to provide follow-up for up to 10 years (83,84).

Only very limited data comparing PCI with medical therapy in patients with LV systolic dysfunction are available (68). In several ways, these data are suboptimal, in that many studies compared CABG with balloon angioplasty, many were retrospective, and many were based on cohort or registry data. Some of the studies demonstrated a similar survival rate in patients having CABG and PCI (71,164,201–203), whereas others showed that those undergoing CABG had better outcomes (32). The data that exist at present on revascularization in patients with CAD and LV systolic dysfunction are more robust for CABG than for PCI, although data from contemporary RCTs in this patient population are lacking. Therefore, the choice of revascularization in patients with CAD and LV systolic dysfunction is best based on clinical variables (e.g., coronary anatomy, presence of diabetes mellitus, presence of CKD), magnitude of LV systolic dysfunction, patient preferences, clinical judgment, and consultation between the interventional cardiologist and the cardiac surgeon.

2.9.5. Previous CABG

In patients with recurrent angina after CABG, repeat revascularization is most likely to improve survival in subjects at highest risk, such as those with obstruction of the proximal LAD artery and extensive anterior ischemia (85–93). Patients with ischemia in other locations and those with a patent LIMA to the LAD artery are unlikely to experience a survival benefit from repeat revascularization (92).

Cohort studies comparing PCI and CABG among post-CABG patients report similar rates of mid- and long-term survival after the 2 procedures (85,88–91,93,204). In the patient with previous CABG who is referred for revascularization for medically refractory ischemia, factors that may support the choice of repeat CABG include vessels unsuitable for PCI, number of diseased bypass grafts, availability of the internal mammary artery for grafting chronically occluded coronary arteries, and good distal targets for bypass graft placement. Factors favoring PCI over CABG include limited areas of ischemia causing symptoms, suitable PCI targets, a patent graft to the LAD artery, poor CABG targets, and comorbid conditions.

2.9.6. Unstable Angina/Non–ST-Elevation Myocardial Infarction

The main difference between management of the patient with SIHD and the patient with UA/NSTEMI is that the impetus for revascularization is stronger in the setting of UA/NSTEMI, because myocardial ischemia occurring as part of an ACS is potentially life threatening, and associated anginal symptoms are more likely to be reduced with a revascularization procedure than with GDMT (205–207). Thus, the indications for revascularization are strengthened by the acuity of presentation, the extent of ischemia, and the ability to achieve full revascularization. The choice of revascularization method is generally dictated by the same considerations used to decide on PCI or CABG for patients with SIHD.

2.9.7. DAPT Compliance and Stent Thrombosis: Recommendation

CLASS III: HARM

1. **PCI with coronary stenting (BMS or DES) should not be performed if the patient is not likely to be able to tolerate and comply with DAPT for the appropriate duration of treatment based on the type of stent implanted (208–211).** ***(Level of Evidence: B)***

The risk of stent thrombosis is increased dramatically in patients who prematurely discontinue DAPT, and stent thrombosis is associated with a mortality rate of 20% to 45% (208). Because the risk of stent thrombosis with BMS is greatest in the first 14 to 30 days, this is the generally

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recommended minimum duration of DAPT therapy for these individuals. Consensus in clinical practice is to treat DES patients for at least 12 months with DAPT to avoid late (after 30 days) stent thrombosis (208,212). Therefore, the ability of the patient to tolerate and comply with at least 30 days of DAPT with BMS treatment and at least 12 months of DAPT with DES treatment is an important consideration in deciding whether to use PCI to treat patients with CAD.

2.10. TMR as an Adjunct to CABG

TMR has been used on occasion in patients with severe angina refractory to GDMT in whom complete revascularization cannot be achieved with PCI and/or CABG. Although the mechanism by which TMR might be efficacious in these patients is unknown (213,214), several RCTs of TMR as sole therapy demonstrated a reduction in anginal symptoms compared with intensive medical therapy alone (109–111,215–217). A single randomized multicenter comparison of TMR (with a holmium:YAG laser) plus CABG and CABG alone in patients in whom some myocardial segments were perfused by arteries considered not amenable to grafting (112) showed a significant reduction in perioperative mortality rate (1.5% versus 7.6%, respectively), and the survival benefit of the TMR–CABG combination was present after 1 year of follow-up (112). At the same time, a large retrospective analysis of data from the STS National Cardiac Database as well as a study of 169 patients from the Washington Hospital Center who underwent combined TMR–CABG, showed no difference in adjusted mortality rate compared with CABG alone (113,218). In short, a TMR–CABG combination does not appear to improve survival compared with CABG alone. In selected patients, however, such a combination may be superior to CABG alone in relieving angina.

2.11. Hybrid Coronary Revascularization: Recommendations

CLASS IIa

1. Hybrid coronary revascularization (defined as the planned combination of LIMA-to-LAD artery grafting and PCI of ≥1 non-LAD coronary arteries) is reasonable in patients with 1 or more of the following (219–225) *(Level of Evidence: B)*:
   a. Limitations to traditional CABG, such as heavily calcified proximal aorta or poor target vessels for CABG (but amenable to PCI);
   b. Lack of suitable graft conduits;
   c. Unfavorable LAD artery for PCI (i.e., excessive vessel tortuosity or CTO).

CLASS IIb

1. Hybrid coronary revascularization (defined as the planned combination of LIMA-to-LAD artery grafting and PCI of ≥1 non-LAD coronary arteries) may be reasonable as an alternative to multivessel PCI or CABG in an attempt to improve the overall risk-benefit ratio of the procedures. *(Level of Evidence: C)*

Hybrid coronary revascularization, defined as the planned combination of LIMA-to-LAD artery grafting and PCI of ≥1 non-LAD coronary arteries (226), is intended to combine the advantages of CABG (i.e., durability of the LIMA graft) and PCI (227). Patients with multivessel CAD (e.g., LAD and ≥1 non-LAD stenoses) and an indication for revascularization are potentially eligible for this approach. Hybrid revascularization is ideal in patients in whom technical or anatomic limitations to CABG or PCI alone may be present and for whom minimizing the invasiveness (and therefore the risk of morbidity and mortality) of surgical intervention is preferred (221) (e.g., patients with severe preexisting comorbidities, recent MI, a lack of suitable graft conduits, a heavily calcified ascending aorta, or a non-LAD coronary artery unsuitable for bypass but amenable to PCI, and situations in which PCI of the LAD artery is not feasible because of excessive tortuosity or CTO).

Hybrid coronary revascularization may be performed in a hybrid suite in one operative setting or as a staged procedure (i.e., PCI and CABG performed in 2 different operative suites, separated by hours to 2 days, but typically during the same hospital stay). Because most hospitals lack a hybrid operating room, staged procedures are usually performed. With the staged procedure, CABG before PCI is preferred, because this approach allows the interventional cardiologist to 1) verify the patency of the LIMA-to-LAD artery graft before attempting PCI of other vessels and 2) minimize the risk of perioperative bleeding that would occur if CABG were performed after PCI (i.e., while the patient is receiving DAPT). Because minimally invasive CABG may be associated with lower graft patency rates compared with CABG performed through a midline sternotomy, it seems prudent to angiographically image all grafts performed through a minimally invasive approach to confirm graft patency (221).

To date, no RCTs involving hybrid coronary revascularization have been published. Over the past 10 years, several small, retrospective series of hybrid revascularization using minimally invasive CABG and PCI have reported low mortality rates (0 to 2%) and event-free survival rates of 83% to 92% at 6 to 12 months of follow-up. The few series that have compared the outcomes of hybrid coronary revascularization with standard CABG report similar outcomes at 30 days and 6 months (219–225).

3. PCI Outcomes

3.1. Definitions of PCI Success

The success of a PCI procedure is best defined by 3 interrelated components: angiographic findings, procedural events, and clinical outcomes.

3.1.1. Angiographic Success

A successful PCI produces sufficient enlargement of the lumen at the target site to improve coronary artery blood flow. A successful balloon angioplasty is defined as the reduction of a minimum stenosis diameter to <50% with a final TIMI flow grade 3 (visually assessed by angiography)

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without side branch loss, flow-limiting dissection, or angiographic thrombus (7). For coronary stents, a minimum stenosis diameter of <20% (as visually assessed by angiography) has previously been the clinical benchmark of an optimal angiographic result. Given improvements in technology and techniques, as well as recognition of the importance of an adequately deployed stent to decrease the risks of stent restenosis and thrombosis (12,228,229), the writing committee concluded that a minimum diameter stenosis of <10% (with an optimal goal of as close to 0% as possible) should be the new benchmark for lesions treated with coronary stenting. As with balloon angioplasty, there should be final TIMI flow grade 3, without occlusion of a significant side branch, flow-limiting dissection, distal embolization, or angiographic thrombus. Problems with determining angiographic success include disparities between the visual assessment and computer-aided quantitative stenosis measurement and self-reporting of success in clinical reports or databases.

3.1.2. Procedural Success

A successful PCI should achieve angiographic success without associated in-hospital major clinical complications (e.g., death, MI, stroke, emergency CABG) (7,8). Issues regarding the diagnosis and prognostic implications of procedure-related MI are discussed in Sections 3.3 and 5.10.

3.1.3. Clinical Success

In the short term, a clinically successful PCI requires both anatomic and procedural success along with relief of signs and/or symptoms of myocardial ischemia. Long-term clinical success requires that the short-term clinical success remain durable and that relief of signs and symptoms of myocardial ischemia persist >9 months after the procedure. Restenosis is the principal cause of lack of long-term clinical success after a short-term clinical success has been achieved. Restenosis is not a complication; it is the expected biological response to vascular injury. The frequency of clinically important restenosis may be judged by the frequency with which subsequent revascularization procedures are performed on target arteries after the index procedure.

3.2. Predictors of Clinical Outcome After PCI

Factors associated with increased PCI complication rates include advanced age, diabetes, CKD, ACS, congestive heart failure, and multivessel CAD (8,230–232). Several models have been developed and refined over the past 2 decades to predict mortality with PCI (230,233–236). At present, perhaps the best accepted system is from the ACC National Cardiovascular Data Registry (NCDR) CathPCI Risk Score system, which uses clinical variables and PCI setting to predict inpatient mortality (Appendix 4A) (236). In general, these models perform very well (C statistic: approximately 0.90), although predictive capability decreases in high-risk patients.

Models have also been developed to predict procedural success. Presently, the modified ACC/AHA score (230) and the SCAI score (Appendix 4B) (237) are both in use, with the latter slightly outperforming the former. Discrimination as measured by the C statistic is generally good to very good (0.70 to 0.82), depending on the outcome variable and patient population.

The angiographic SYNTAX score (238) has been developed to predict long-term risk of MACE after multivessel intervention. The SYNTAX score and its potential utility in helping guide revascularization strategies are discussed in Section 2. Composite models including angiographic and clinical variables have been developed but generally require validation in larger cohorts of patients.

3.3. PCI Complications

In an analysis of the NCDR CathPCI database of patients undergoing PCI between 2004 and 2007, the overall in-hospital mortality rate was 1.27%, ranging from 0.65% in elective PCI to 4.81% in STEMI (236). Factors associated with an increased risk of PCI-related death include advanced age, comorbidities (e.g., diabetes, CKD, congestive heart failure), multivessel CAD, high-risk lesions, and the setting of PCI (e.g., STEMI, urgent or emergency procedure, cardiogenic shock) (56,230–232,236).

Causes of procedural and periprocedural MI include acute artery closure, embolization and no-reflow, side branch occlusion, and acute stent thrombosis. The incidence of procedure-related MI depends to a great degree on the definition of MI used, the patient population studied, and whether or not cardiac biomarkers are routinely assessed after PCI. The definition and clinical significance of PCI-related MI have been controversial. Criteria for defining a PCI-related MI have evolved over time (8,239,240). The 2007 universal definition of MI (240) states that after PCI, elevations of cardiac biomarkers above the 99th percentile upper reference limit indicate periprocedural myocardial necrosis. Increases of biomarkers >3 times the 99th percentile upper reference limit were designated as defining PCI-related MI (240). According to this definition, ≥15% of patients undergoing PCI would be defined as having periprocedural MI (241,242). Issues in procedure-related MI are discussed in Section 5.10.

The need for emergency CABG has dramatically decreased with advances in PCI technology, particularly coronary stents (243,244). Recently the NCDR reported the rate of emergency CABG at 0.4% (244). Procedure-related indications for CABG in 1 large series included coronary dissection (27%), acute artery closure (16%), perforation (8%), and failure to cross the lesion (8%) (245). The strongest predictors of the need for emergency CABG in several analyses are cardiogenic shock (OR: 11.4), acute MI or emergency PCI (OR: 3.2 to 3.8), multivessel disease (OR: 2.3 to 2.4), and type C lesion (OR: 2.6) (243,245). In-hospital mortality for emergency CABG ranges from 7.8% to 14% (243,245,246).

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In a contemporary analysis from the NCDR, the incidence of PCI-related stroke was 0.22% (247). In-hospital mortality in patients with PCI-related stroke is 25% to 30% (247,248). Factors associated with an increased risk of stroke include fibrinolytic therapy administered before PCI (OR: 4.7), known cerebrovascular disease (OR: 2.20), STEMI as the indication for PCI (OR: 3.2), use of an intra-aortic balloon pump (IABP) (OR: 2.6), older age (OR: 1.17 per 5-year increase), and female sex (247–249). Initial imaging after a stroke in 1 small series revealed hemorrhagic etiology in 18%, ischemic etiology in 58%, and no clear etiology in 24% (248). One potential algorithm for the treatment of catheterization-related stroke has been recently proposed (250). This document includes no specific recommendations for the management of PCI-related stroke but refers the reader to the AHA/American Stroke Association guidelines for the management of adults with stroke (251).

Vascular complications from PCI are primarily related to vascular access. Important femoral vascular complications include access site hematoma, retroperitoneal hematoma, pseudoaneurysm, arteriovenous fistula, and arterial dissection and/or occlusion (252). The incidence of these vascular complications in various reports generally ranges from 2% to 6% and has decreased with time (249,253–257). Factors associated with an increased risk of vascular complication include age ≥70 years, body surface area <1.6 m^2, emergency procedures, peripheral artery disease, periprocedural use of glycoprotein (GP) IIb/IIIa inhibitors, and female sex (if not corrected for body surface area) (249,253,254,257,258). Ultrasound guidance has been used for femoral artery access to potentially decrease complications (259). As discussed in Section 5.11, vascular closure devices have not been clearly demonstrated to decrease vascular complication rates. Radial site access decreases the rate of access-related bleeding and complications compared with femoral access (255,260). Loss of the radial pulse has been reported in ≤5% of radial procedures (261). Infrequent to rare complications occurring with the radial artery approach include compartment syndrome, pseudoaneurysm (<0.01%), and sterile abscess (occurring with previous-generation hydrophilic sheaths) (262). Radial artery spasm may occur and treatment at times may be challenging. Local hematomas may occur from small-branch vessel hydrophilic wire perforation or inexperience with wristband use.

The risk of coronary perforation is approximately 0.2%, most commonly by wire perforation during PCI for CTO or by ablative or oversized devices during PCI of heavily diseased or tortuous coronary arteries (263). The risk of tamponade and management of the perforation varies with the type of perforation (264).

Periprocedural bleeding is now recognized to be associated with subsequent mortality (265,266), and the avoidance of bleeding complications has become an important consideration in performing PCI. The risk of bleeding is associated with patient factors (e.g., advanced age, low body mass index, CKD, baseline anemia), as well as the degree of platelet and thrombin inhibition, vascular access site, and sheath size (267–269). Issues of periprocedural bleeding are discussed in Section 4.7.

The incidence of contrast-induced acute kidney injury (AKI) or "contrast nephropathy" in published reports depends on the definition of contrast nephropathy used and the frequency of risk factors for contrast-induced AKI in the patient population studied. Important risk factors for contrast-induced AKI include advanced age, CKD, congestive heart failure, diabetes, and the volume of contrast administered. Contrast-induced AKI and strategies to prevent it are discussed in Section 4.4.

4. Preprocedural Considerations

Table 4 contains recommendations for preprocedural considerations and interventions in patients undergoing PCI.

4.1. Cardiac Catheterization Laboratory Requirements

4.1.1. Equipment

Defibrillators are considered by The Joint Commission to be life-support equipment requiring routine assessment and completion of appropriate logs. Many hospitals require periodic inspection of consoles for ancillary devices used in coronary intervention (e.g., Doppler wires, pressure-tipped sensor wires, and IVUS catheters). Point-of-care testing devices (e.g., activated clotting time and arterial blood gas machines) require routine calibration. Duration of storage of digital cine images is often mandated by law. Operating parameters for x-ray imaging equipment are adjusted at installation and periodically assessed by a qualified physicist in cooperation with the equipment manufacturer. Familiarity with radiation dose–reducing features of catheterization laboratory equipment and assistance from a qualified physicist are important for radiation dose minimization and image optimization.

4.1.2. Staffing

An interventional cardiologist must be present in the laboratory for the duration of each procedure and is responsible for procedure outcome. Nursing and technical personnel are also required to be present in the catheterization laboratory, with specific staffing dependent on state requirements and laboratory caseload and mix. Catheterization laboratory technical staff may include nurse practitioners, registered nurses, licensed vocational or practical nurses, physician assistants, nursing assistants, radiology technicians, or catheterization laboratory technicians. All catheterization laboratory staff are usually certified in basic life support, advanced cardiovascular life support, and, where appropriate, pediatric advanced life support. Catheterization laboratory personnel have a nursing degree/certification or invasive cardiovascular credentials such as registered cardio-

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Table 4. Summary of Recommendations for Preprocedural Considerations and Interventions in Patients Undergoing PCI

Recommendations	COR	LOE	References
Contrast-induced AKI			
Patients should be assessed for risk of contrast-induced AKI before PCI.	I	C	(270,271)
Patients undergoing cardiac catheterization with contrast media should receive adequate preparatory hydration.	I	B	(272–275)
In patients with CKD (creatinine clearance <60 mL/min), the volume of contrast media should be minimized.	I	B	(276–278)
Administration of N-acetyl-L-cysteine is not useful for the prevention of contrast-induced AKI.	III: No Benefit	A	(279–283)
Anaphylactoid reactions			
Patients with prior evidence of an anaphylactoid reaction to contrast media should receive appropriate prophylaxis before repeat contrast administration.	I	B	(252,284–286)
In patients with a prior history of allergic reactions to shellfish or seafood, anaphylactoid prophylaxis for contrast reaction is not beneficial.	III: No Benefit	C	(287–289)
Statins			
Administration of a high-dose statin is reasonable before PCI to reduce the risk of periprocedural MI.	IIa	A: Statin naïve	(290–296)
		B: Chronic statin therapy	(297)
Bleeding risk			
All patients should be evaluated for risk of bleeding before PCI.	I	C	N/A
CKD			
In patients undergoing PCI, the glomerular filtration rate should be estimated and the dosage of renally cleared medications should be adjusted.	I	B	(298–300)
Aspirin			
Patients already on daily aspirin therapy should take 81 mg to 325 mg before PCI.	I	B	(301–304)
Patients not on aspirin therapy should be given nonenteric aspirin 325 mg before PCI.	I	B	(301,303,304)

AKI indicates acute kidney injury; CKD, chronic kidney disease; COR, class of recommendation; LOE, level of evidence; MI, myocardial infarction; N/A, not applicable; and PCI, percutaneous coronary intervention.

vascular invasive specialist or American Society of Radiation technologists (305).

4.1.3. 'Time-Out' Procedures

In 2003, The Joint Commission mandated a universal protocol requiring proper preoperative identification of the patient by the members of the catheterization laboratory team, marking of the operative site, and a final time-out just before the procedure (306). Although initially intended to prevent wrong-site surgery, this has been expanded to include all invasive procedures despite limited scientific evidence of its effectiveness (307). The intent of the time-out is for all members of the team to improve patient care by collectively discussing the case. The content of a time-out includes confirmation of the correct patient, correct side and site, agreement on the procedure to be performed, correct patient position, and availability of needed equipment, supplies, and implants. The time-out may be checklist driven or conversational, depending on laboratory preferences (308). The writing committee strongly endorses the practice of conducting a time-out before all PCI procedures.

4.2. Ethical Aspects

The 3 principles of medical ethics are beneficence, autonomy, and justice. Beneficence involves the physician's duty to act in the best interests of the patient and avoid maleficence, or harm (*primum non nocere*). Autonomy describes the physician's duty to help the patient maintain control over his or her medical treatments. Justice describes the physician's duty to treat the individual patient responsibly with due consideration of other patients and stakeholders in the healthcare system. Ethical considerations specific to PCI have been previously discussed (309) and are highlighted below:

- Place the patient's best interest first and foremost when making clinical decisions (beneficence).
- Ensure that patients actively participate in decisions affecting their care (autonomy).
- Consider how decisions regarding one patient may also affect other patients and providers (justice).
- Plan and perform procedures and provide care with the intention of improving the patient's quality of life and/or decreasing the risk of mortality, independent of reimbursement considerations and without inappropriate bias or influence from industry, administrators, referring physicians, or other sources.
- Before performing procedures, obtain informed consent after giving an explanation regarding the details of the procedure and the risks and benefits of both the procedure and alternatives to the procedure.
- Plan and perform procedures according to standards of care and recommended guidelines, and deviate from them when appropriate or necessary in the care of individual patients.

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- Seek advice, assistance, or consultation from colleagues when such consultation would benefit the patient.

4.2.1. Informed Consent

Obtaining informed consent for procedures is a legal and ethical necessity. Ideally, informed consent is obtained long enough before the procedure that the patient can fully consider informed consent issues and discuss them with family or other providers, avoiding any sense of coercion. Ad hoc PCI, or PCI immediately following diagnostic procedures, presents special problems. When informed consent for PCI is obtained before diagnostic catheterization is performed, it is impossible to predict the levels of risk and benefit from an ad hoc PCI (310,311). If diagnostic catheterization reveals anatomy that poses a particularly high risk or for which the superiority of PCI compared with other strategies is unclear, the precatheterization informed consent discussion may be inadequate. In such cases, deferral of PCI until additional informed consent discussions and/or consultations occur may be appropriate, even though it inconveniences the patient and the healthcare system. It is the responsibility of the interventionalist to act in the patient's best interest in these circumstances.

Informed consent before emergency procedures is particularly difficult (312–314). The patient presenting with STEMI is usually in distress and often sedated, making true informed consent impossible. Rapid triage, transport, and treatment of STEMI patients create a pressured atmosphere that by necessity limits a prolonged and detailed informed consent process. Nevertheless, the interventionist must attempt to provide information about the risks and benefits of different strategies to the patient and family and balance the benefit of thorough discussion with the benefits of rapid intervention.

4.2.2. Potential Conflicts of Interest

Decisions about the performance and timing of PCI may pose additional ethical dilemmas. When considering whether to perform multivessel PCI in 1 stage versus 2 stages, safety and convenience for the patient must guide the decision, regardless of payment policies that maximize reimbursement when PCI is staged (311). A separate issue is self-referral, through which diagnostic catheterization often leads seamlessly to PCI by the same operator (315). The interventionist has an ethical obligation to the patient to consider all treatment options, consult with additional specialists (e.g., cardiac surgeons) when their input would be helpful to the patient, avoid unnecessary interventional procedures, and allow the patient to consult family members and other physicians (311).

4.3. Radiation Safety: Recommendation

CLASS I

1. Cardiac catheterization laboratories should routinely record relevant available patient procedural radiation dose data (e.g., total air kerma at the international reference point [$K_{a,r}$], air kerma air product [P_{KA}], fluoroscopy time, number of cine images), and should define thresholds with corresponding follow-up protocols for patients who receive a high procedural radiation dose. *(Level of Evidence: C)*

The issue of radiation exposure during imaging procedures has received increased attention, and the writing committee believes that radiation safety should be addressed in this guideline. Current standards for cardiac catheterization laboratories include the following:

- Specific procedures and policies are in place to minimize patient (and operator) risk.
- A radiation safety officer coordinates all radiation safety issues and works conjointly with the medical or health physicist.
- Patient radiation exposure is reduced to as low a level as reasonably can be achieved.
- Patients at increased risk for high procedural radiation exposure are identified.
- Informed consent includes radiation safety information, particularly for the high-risk patient.

A basic primer on the physics of x-ray imaging, essential to the safe practice of radiation dose management, has been published in an ACCF/AHA/Heart Rhythm Society/SCAI clinical competence statement (316). Appendix 4C summarizes strategies to minimize patient and operator radiation exposure. Adverse radiation effects are now well recognized as infrequent but potentially serious complications of prolonged interventional procedures (317). Fluoroscopic time does not include cine acquisition imaging and is therefore not an accurate measure of patient radiation dose. Total air kerma at the interventional reference point ($K_{a,r,}$ in G_y) and air kerma area product (P_{KA}, in $Gycm^2$) are required to be reported on interventional x-ray systems since 2006. These are useful in the assessment of potential tissue adverse effects or long-term radiation sequelae, respectively, and it is reasonable to include them in the catheterization record at the conclusion of each procedure. Appendix 4D summarizes considerations for patient follow-up based on radiation dose during the procedure (317).

4.4. Contrast-Induced AKI: Recommendations

CLASS I

1. Patients should be assessed for risk of contrast-induced AKI before PCI (270,271). *(Level of Evidence: C)*
2. Patients undergoing cardiac catheterization with contrast media should receive adequate preparatory hydration (272–275). *(Level of Evidence: B)*
3. In patients with CKD (creatinine clearance <60 mL/min), the volume of contrast media should be minimized (276–278). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. Administration of N-acetyl-L-cysteine is not useful for the prevention of contrast-induced AKI (279–283). *(Level of Evidence: A)*

See Online Data Supplements 16 to 18 for additional data regarding contrast–induced AKI.

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Contrast-induced AKI or "contrast nephropathy" is one of the leading causes of hospital-acquired AKI. Major risk factors for contrast-induced AKI include advanced age, CKD, congestive heart failure, diabetes, and the volume of contrast administered. A risk-scoring system is available to predict the risk of contrast nephropathy using these risk factors and additional variables (270). Thus far, the only strategies clearly shown to reduce the risk of contrast-induced AKI are hydration and minimizing the amount of contrast media. Other than saline hydration, measures that were believed to reduce the risk of contrast-induced AKI have been found to be neutral, to have deleterious effects, or to be characterized by heterogeneous and conflicting data.

Studies of hydration to reduce the risk of contrast-induced AKI suggest that isotonic saline is preferable to half isotonic saline, intravenous (IV) hydration is preferable to oral hydration, hydration for hours before and after exposure to contrast media is preferable to a bolus administration of saline immediately before or during contrast media exposure, and administration of isotonic saline alone is preferable to administration of isotonic saline plus mannitol or furosemide (272–275,320). On the basis of these studies, a reasonable hydration regimen would be isotonic crystalloid (1.0 to 1.5 mL/kg per hour) for 3 to 12 hours before the procedure and continuing for 6 to 24 hours after the procedure (272–275,284,320,321).

Prior studies of N-acetyl-L-cysteine and sodium bicarbonate have produced conflicting results. Some, often small, earlier studies suggested benefit, but many other more contemporary studies and meta-analyses found no clear evidence of benefit, and there are potential issues of publication bias and poor methodology issues in several analyses (279–282,322–332). The recently completed largest randomized study on N-acetyl-L-cysteine and contrast nephropathy in patients undergoing angiographic procedures, ACT (Acetylcysteine for Contrast-Induced Nephropathy Trial), demonstrated no benefit in primary or secondary endpoints. An updated meta-analysis using only high-quality trials similarly demonstrated no benefit (283). Taken as a whole, these studies do not support any recommendation for the use of N-acetyl-L-cysteine, they do, however, provide sufficient data to conclude that N-acetyl-L-cysteine does not prevent contrast-induced AKI in patients undergoing angiographic procedures.

The correlation between the volume of contrast media and the risk of contrast-induced AKI has been documented in several studies (276,277). Thus, minimization of contrast media volume is important to prevent contrast-induced AKI in patients undergoing angiography. The volume of contrast already administered during diagnostic catheterization is an important factor when considering possible "ad hoc" PCI.

Comparative studies of different contrast media (e.g., low-osmolar versus iso-osmolar, one agent versus another agent) have produced variable and sometimes contradictory results (334–339). Thus, current data are insufficient to justify specific recommendations about low- and iso-osmolar contrast media. This issue is discussed in detail in the 2011 UA/NSTEMI focused update (340). For a further discussion of contrast media and PCI, the reader is referred to a position statement by the SCAI (284).

4.5. Anaphylactoid Reactions: Recommendations

CLASS I

1. Patients with prior evidence of an anaphylactoid reaction to contrast media should receive appropriate steroid and antihistamine prophylaxis before repeat contrast administration (252,284–286). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. In patients with a prior history of allergic reactions to shellfish or seafood, anaphylactoid prophylaxis for contrast reaction is not beneficial (287–289). *(Level of Evidence: C)*

The incidence of anaphylactoid reactions to contrast media is ≤1%, and the incidence of severe reactions may be as low as 0.04% (284). Limited data suggest that in patients with a history of prior anaphylactoid reaction, the recurrence rate without prophylaxis is in the range of 16% to 44% (341). Adequate pretreatment of patients with prior anaphylactoid reactions reduces the recurrence rate to close to zero (284–286). A regimen of 50 mg of prednisone administered 13 hours, 7 hours, and 1 hour before the procedure (as well as 50 mg of diphenhydramine 1 hour before the procedure) has been shown to reduce the risk of recurrent anaphylactoid reaction (286). In practice, a regimen of 60 mg of prednisone the night before and morning of the procedure (as well as 50 mg of diphenhydramine 1 hour before the procedure) is often used (252). There are minimal data on the "pretreatment" of patients undergoing emergency PCI (342). One group has suggested IV steroids (e.g., 80 mg to 125 mg of methylprednisolone, 100 mg of hydrocortisone sodium succinate), as well as oral or IV diphenhydramine and possible IV cimetidine (284). For a more detailed discussion of issues related to contrast-induced anaphylactoid reactions, the reader is referred to several dedicated discussions on contrast agents (284,341).

There are no data to suggest that those patients with seafood or shellfish allergies are at risk for an anaphylactoid reaction from exposure to contrast media. Iodine does not mediate seafood, shellfish, or contrast media reactions. The common misconception that seafood allergies and contrast reactions are cross-reactions to iodine probably arose from a survey published in 1975 in which 15% of patients with a history of contrast reaction reported a personal history of shellfish allergy, but nearly identical proportions of patients reported allergies to other foods, such as milk and egg, in the same survey (287). Pretreatment of patients with steroids based only on a history of seafood or shellfish allergy has a small but non-zero risk of adverse effect (e.g., hyperglycemia in a patient with diabetes) without any demonstrated benefit (288,289).

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4.6. Statin Treatment: Recommendation

CLASS IIa

1. Administration of a high-dose statin is reasonable before PCI to reduce the risk of periprocedural MI. *(Level of Evidence: A for statin-naïve patients* [290–296]; *Level of Evidence: B for those on chronic statin therapy* [297]*)*

See Online Data Supplement 19 for additional data regarding preprocedural statin treatment.

Statins have long-term benefits in patients with CAD (343,344) and ACS (345,346). The benefits of statins in ACS begin early, before substantial lipid lowering has occurred (345,347), suggesting pleiotropic effects of statins. These might include anti-inflammatory effects, improvement of endothelial function, decrease of oxidative stress, or inhibition of thrombogenic responses (348). Statins were beneficial when pretreatment was started from 7 days to just before PCI (290–297).

4.7. Bleeding Risk: Recommendation

CLASS I

1. All patients should be evaluated for risk of bleeding before PCI. *(Level of Evidence: C)*

Periprocedural bleeding is now recognized as a major risk factor for subsequent mortality (265,266). Bleeding may lead to mortality directly (because of the bleeding event) or through ischemic complications that occur when antiplatelet or anticoagulant agents are withdrawn in response to the bleeding. Bleeding may also be a marker of comorbidities associated with worse prognosis (e.g., occult cancer). The risk of bleeding is associated with a number of patient factors (e.g., advanced age, low body mass index, CKD, baseline anemia), as well as the degree of platelet and thrombin inhibition, vascular access site, and sheath size (267–269). The overall approach to PCI should be individualized to minimize both ischemic and bleeding risks.

Measures to minimize the risks of bleeding complications are discussed in several sections of this guideline. These include use of anticoagulation regimens associated with a lower risk of bleeding, weight-based dosing of heparin and other agents, use of activated clotting times to guide unfractionated heparin (UFH) dosing, avoidance of excess anticoagulation (349), dosing adjustments in patients with CKD (e.g., eptifibatide, tirofiban, bivalirudin) (350), use of radial artery access site (255), and avoidance of femoral vein cannulation when possible. Vascular closure devices have not been clearly demonstrated to decrease bleeding complications and are discussed in detail in Section 5.11.

4.8. PCI in Hospitals Without On-Site Surgical Backup: Recommendations

CLASS IIa

1. Primary PCI is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished (351,352). *(Level of Evidence: B)*

CLASS IIb

1. Elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection (352–354). *(Level of Evidence: B)*

CLASS III: HARM

1. Primary or elective PCI should not be performed in hospitals without on-site cardiac surgery capabilities without a proven plan for rapid transport to a cardiac surgery operating room in a nearby hospital or without appropriate hemodynamic support capability for transfer. *(Level of Evidence: C)*

See Online Data Supplement 20 for additional data regarding hospitals without on-site surgical backup.

Primary and elective PCI can be performed at hospitals without on-site cardiac surgical backup with a high success rate, low in-hospital mortality rate, and low rate for emergency CABG (351,353,354). The best outcomes for patients with STEMI are achieved at hospitals with 24/7 access to primary PCI (355). Criteria for the performance of PCI without on-site surgical backup have been proposed in an SCAI expert consensus document (352). Consideration of elective PCI without on-site cardiac surgical backup is thought to be appropriate only when performed by experienced operators with complication rates and outcomes equivalent or superior to national benchmarks. Accurate assessment of complication rates and patient outcomes via a regional or national data registry, so that outcomes can be compared with established benchmarks, is an important quality control component of any PCI program. Desires for personal or institutional financial gain, prestige, market share, or other similar motives are not appropriate considerations for initiation of PCI programs without on-site cardiac surgery. It is only appropriate to consider initiation of a PCI program without on-site cardiac surgical backup if this program will clearly fill a void in the healthcare needs of the community. Competition with another PCI program in the same geographic area, particularly an established program with surgical backup, may not be in the best interests of the community.

Tables 5 and 6 list the SCAI expert consensus document requirements for PCI programs without on-site surgical backup. Table 7 gives the requirements for primary PCI and emergency CABG at hospitals without on-site cardiac surgery, and Table 8 lists the requirements for patient and lesion selection and backup strategy for nonemergency PCI (352).

5. Procedural Considerations

5.1. Vascular Access: Recommendation

CLASS IIa

1. The use of radial artery access can be useful to decrease access site complications (255,260,356–362). *(Level of Evidence: A)*

See Online Data Supplement 21 for additional data regarding radial access.

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Table 5. SCAI Expert Consensus Document Personnel and Facility Requirements for PCI Programs Without On-Site Surgical Backup

Experienced nursing and technical laboratory staff with training in interventional laboratories. Personnel must be comfortable treating acutely ill patients with hemodynamic and electrical instability.
On-call schedule with operation of laboratory 24 h/d, 365 d/y.*
Experienced coronary care unit nursing staff comfortable with invasive hemodynamic monitoring, operation of temporary pacemaker, and management of IABP. Personnel capable of endotracheal intubation and ventilator management both on-site and during transfer if necessary.
Full support from hospital administration in fulfilling the necessary institutional requirements, including appropriate support services (e.g., respiratory care, blood bank).
Written agreements for emergency transfer of patients to a facility with cardiac surgery. Transport protocols should be developed and tested a minimum of 2 times per year.
Well-equipped and maintained cardiac catheterization laboratory with high-resolution digital imaging capability and IABP equipment compatible with transport vehicles. The capability for real-time transfer of images and hemodynamic data (via T-1 transmission line) as well as audio and video images to review terminals for consultation at the facility providing surgical backup support is ideal.
Appropriate inventory of interventional equipment, including guide catheters, balloons, and stents in multiple sizes; thrombectomy and distal protection devices; covered stents; temporary pacemakers; and pericardiocentesis trays. Pressure wire device and IVUS equipment are optimal but not mandatory. Rotational or other atherectomy devices should be used cautiously in these facilities because of the greater risk of perforation.
Meticulous clinical and angiographic selection criteria for PCI (Tables 6 and 7).
Performance of primary PCI as the treatment of first choice for STEMI to ensure streamlined care paths and increased case volumes. Door-to-balloon times should be tracked, and <90 min outlier cases should be carefully reviewed for process improvement opportunities.
On-site rigorous data collection, outcomes analysis, benchmarking, quality improvement, and formalized periodic case review.
Participation in a national data registry where available, such as the ACC NCDR in the United States.

*Required for U.S. facilities but may not be possible for all facilities worldwide.
ACC indicates American College of Cardiology; IABP, intra-aortic balloon pump; IVUS, intravascular ultrasound; NCDR, National Cardiovascular Data Registry; PCI, percutaneous coronary intervention; SCAI, Society for Cardiovascular Angiography and Interventions; and STEMI, ST-elevation myocardial infarction.
Adapted with permission from Dehmer et al. (352).

Femoral artery access remains the most commonly used approach in patients undergoing PCI in the United States. Choosing a femoral artery puncture site is facilitated by fluoroscopic landmark identification or ultrasound guidance. Low punctures have a high incidence of peripheral artery complications, whereas high punctures have an increased risk of retroperitoneal hemorrhage. In patients with a synthetic graft, arterial access is possible after the graft is a few months old and complication rates are not increased (254).

Radial site access is used frequently in Europe and Canada but not in the United States (260). A learning curve exists for the radial approach that will affect procedure time and radiation dose, with a trend toward lower procedural success rates for radial versus femoral access (255). However, compared with femoral access, radial access decreases the rate of access-related bleeding and complications (255,260,363). In a recent large RCT comparing radial and femoral access in patients with ACS undergoing PCI, there was no difference in the primary composite endpoint (death, MI, stroke, major bleeding), although there was a lower rate of vascular complications with the use of radial access (362). Radial artery access is particularly appealing in patients with coagulopathy, elevated international normalized ratio due to warfarin, or morbid obesity.

5.2. PCI in Specific Clinical Situations

5.2.1. UA/NSTEMI: Recommendations

CLASS I

1. An early invasive strategy (i.e., diagnostic angiography with intent to perform revascularization) is indicated in UA/NSTEMI patients who have refractory angina or hemodynamic or electrical instability

Table 6. SCAI Expert Consensus Document Requirements for Off-Site Surgical Backup

1. Interventional cardiologists establish a working relationship with cardiac surgeons at the receiving facility.
2. Cardiac surgeon must have privileges at the referring facility to allow review of treatment options as time allows.
3. Cardiac surgeon and receiving hospital agree to provide cardiac surgical backup for urgent cases at all hours and for elective cases at mutually agreed hours.
4. Surgeon and receiving facility ensure that patients will be accepted based on medical condition, capacity of surgeon to provide services at the time of request, and availability of resources. If this cannot be ensured before the start of an elective procedure, the case should not be done at this time.
5. Interventional cardiologists must review with surgeons the immediate needs and status of any patient transferred for urgent surgery.
6. Hospital administrations from both facilities endorse transfer agreement.
7. Transferring and receiving facilities establish a rigorous protocol for rapid transfer of patients, including the proper personnel with appropriate experience.
8. A transport provider is available to begin transport within 20 min of the request and provide vehicle/helicopter with necessary life-sustaining equipment, including IABP and monitoring capability.
9. Transferring physician obtains consent for surgery from patient or appropriate surrogate.
10. Initial informed consent for PCI discloses that the procedure is being done without on-site surgical backup and acknowledges the possibility of risks related to transfer. The consent process should include the risk of urgent surgery (approximately 0.3%) and state that a written plan for transfer exists.
11. As part of the local continuous quality improvement program, a regular review of all patients transferred for emergency surgery with the outcome of surgery and identification of any improvement opportunities.

IABP indicates intra-aortic balloon pump; PCI, percutaneous coronary intervention; and SCAI, Society for Cardiovascular Angiography and Interventions.
Adapted with permission from Dehmer et al. (352).

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Table 7. SCAI Expert Consensus Document Requirements for Primary PCI and Emergency Aortocoronary Bypass Surgery at Hospitals Without On-Site Cardiac Surgery

Avoid intervention in patients with

- >50% diameter stenosis of left main artery proximal to infarct-related lesion, especially if the area in jeopardy is relatively small and overall LV function is not severely impaired
- Long, calcified, or severely angulated target lesions at high risk for PCI failure with TIMI flow grade 3 present during initial diagnostic angiography
- Lesions in other than the infarct artery (unless they appeared to be flow limiting in patients with hemodynamic instability or ongoing symptoms)
- Lesions with TIMI flow grade 3 that are not amenable to stenting in patients with left main or 3-vessel disease that will require coronary bypass surgery
- Culprit lesions in more distal branches jeopardizing only a modest amount of myocardium when there is more proximal disease that could be worsened by attempted intervention

Transfer emergently for coronary bypass surgery patients with

- High-grade left main or 3-vessel coronary disease with clinical or hemodynamic instability after successful or unsuccessful PCI of an occluded vessel and preferably with IABP support
- Failed or unstable PCI result and ongoing ischemia, with IABP support during transfer

IABP indicates intra-aortic balloon pump; LV, left ventricular; PCI, percutaneous coronary intervention; SCAI, Society for Cardiovascular Angiography and Interventions; and TIMI, Thrombolysis In Myocardial Infarction.

Adapted with permission from Dehmer et al. (352).

(without serious comorbidities or contraindications to such procedures) (207,364,365). *(Level of Evidence: B)*

2. An early invasive strategy (i.e., diagnostic angiography with intent to perform revascularization) is indicated in initially stabilized UA/NSTEMI patients (without serious comorbidities or contraindications to such procedures) who have an elevated risk for clinical events (207,365–367). *(Level of Evidence: A)*
3. The selection of PCI or CABG as the means of revascularization in the patient with ACS should generally be based on the same considerations as those without ACS (53,156,207,368). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. An early invasive strategy (i.e., diagnostic angiography with intent to perform revascularization) is not recommended in patients with extensive comorbidities (e.g., liver or pulmonary failure, cancer) in whom *(Level of Evidence: C)*
   a. The risks of revascularization and comorbid conditions are likely to outweigh the benefits of revascularization,
   b. There is a low likelihood of ACS despite acute chest pain, or
   c. Consent to revascularization will not be granted regardless of the findings.

The goals of coronary angiography and revascularization in UA/NSTEMI patients are to reduce the risk of death and MI and provide symptom relief. To improve prognosis, early risk stratification is essential for selection of medical and/or invasive treatment strategies. Indications for revascularization depend on the patient's clinical risk characteristics and coronary anat-

Table 8. SCAI Expert Consensus Document Requirements for Patient and Lesion Selection and Backup Strategy for Nonemergency PCI by Experienced Operators at Hospitals Without On-Site Cardiac Surgery

Patient risk: expected clinical risk in case of occlusion caused by procedure

High patient risk: Patients with any of the following:

- Decompensated congestive heart failure (Killip Class 3) without evidence for active ischemia, recent CVA, advanced malignancy, known clotting disorders
- LVEF <25%
- Left main stenosis (≥50% diameter) or 3-vessel disease unprotected by prior bypass surgery (>70% stenoses in the proximal segment of all major epicardial coronary arteries)
- Single-target lesion that jeopardizes >50% of remaining viable myocardium

Lesion risk: probability that procedure will cause acute vessel occlusion

Increased lesion risk: lesions in open vessels with any of the following characteristics:

- Diffuse disease (>2 cm in length) and excessive tortuosity of proximal segments
- More than moderate calcification of a stenosis or proximal segment
- Location in an extremely angulated segment (>90%)
- Inability to protect major side branches
- Degenerated older vein grafts with friable lesions
- Substantial thrombus in the vessel or at the lesion site
- Any other feature that may, in the operator's judgment, impede successful stent deployment

Aggressive measures to open CTOs are also discouraged because of an increased risk of perforation.

Strategy for surgical backup based on lesion and patient risk:

- **High-risk patients with high-risk lesions** should not undergo nonemergency PCI at a facility without on-site surgery.
- **High-risk patients with non–high-risk lesions:** Nonemergency patients with this profile may undergo PCI, but confirmation that a cardiac surgeon and operating room are immediately available is necessary.
- **Non–high-risk patients with high-risk lesions** require no additional precautions.
- **Non–high-risk patients with non–high-risk lesions** require no additional precautions. Best scenario for PCI without on-site surgery.

CTO indicates chronic total occlusion; CVA, cerebrovascular accident; LVEF, left ventricular ejection fraction; PCI, percutaneous coronary intervention; and SCAI, Society for Cardiovascular Angiography and Interventions.

Adapted with permission from Dehmer et al. (352).

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Table 9. Indications for Coronary Angiography in STEMI

Indications	COR	LOE	References
Immediate coronary angiography			
Candidate for primary PCI	I	A	(351,379–382)
Severe heart failure or cardiogenic shock (if suitable revascularization candidate)	I	B	(383,384)
Moderate to large area of myocardium at risk and evidence of failed fibrinolysis	IIa	B	(385,386)
Coronary angiography 3 to 24 h after fibrinolysis			
Hemodynamically stable patients with evidence for successful fibrinolysis	IIa	A	(387–391)
Coronary angiography before hospital discharge			
Stable patients	IIb	C	N/A
Coronary angiography at any time			
Patients in whom the risks of revascularization are likely to outweigh the benefits or the patient or designee does not want invasive care	III: No Benefit	C	N/A

COR indicates class of recommendation; LOE, level of evidence; N/A, not applicable; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

omy and are in general stronger in the presence of high-risk clinical presentation (e.g., dynamic electrocardiogram [ECG] changes, elevated troponin, high Global Registry of Acute Coronary Events score), recurrent symptoms, threatened viable myocardium, CKD, and larger ischemic burden (Appendix 4E). For choice of revascularization technique, the anatomical considerations are generally those used for stable CAD, although PCI may initially be performed in the index lesion to stabilize the patient (Section 2).

Contemporary studies variably comparing strategies of very early (within hours of admission), early (within 24 hours of admission), and delayed (1 to 7 days after admission) cardiac catheterization and revascularization support a strategy of *early* angiography and revascularization to reduce the risk of recurrent ischemia and MI, particularly among those at high risk (e.g., Global Registry of Acute Coronary Events score >140) (367,369,370), whereas a delayed approach is reasonable in low-intermediate risk patients (based on clinical course). There is no evidence that incremental benefit is derived by angiography and PCI performed within the first few hours of hospital admission (207,367,371–378).

5.2.2. ST-Elevation Myocardial Infarction

5.2.2.1. CORONARY ANGIOGRAPHY STRATEGIES IN STEMI: RECOMMENDATIONS

CLASS I

1. A strategy of immediate coronary angiography with intent to perform PCI (or emergency CABG) in patients with STEMI is recommended for
   a. Patients who are candidates for primary PCI (351,379–382). *(Level of Evidence: A)*
   b. Patients with severe heart failure or cardiogenic shock who are suitable candidates for revascularization (383,384). *(Level of Evidence: B)*

CLASS IIa

1. A strategy of immediate coronary angiography (or transfer for immediate coronary angiography) with intent to perform PCI is reasonable for patients with STEMI, a moderate to large area of myocardium at risk, and evidence of failed fibrinolysis (385,386). *(Level of Evidence: B)*
2. A strategy of coronary angiography (or transfer for coronary angiography) 3 to 24 hours after initiating fibrinolytic therapy with intent to perform PCI is reasonable for hemodynamically stable patients with STEMI and evidence for successful fibrinolysis when angiography and revascularization can be performed as soon as logistically feasible in this time frame (387–391). *(Level of Evidence: A)*

CLASS IIb

1. A strategy of coronary angiography performed before hospital discharge might be reasonable in stable patients with STEMI who did not undergo cardiac catheterization within 24 hours of STEMI onset. *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. A strategy of coronary angiography with intent to perform PCI is not recommended in patients with STEMI in whom the risks of revascularization are likely to outweigh the benefits or when the patient or designee does not want invasive care. *(Level of Evidence: C)*

The historical reperfusion strategies of "primary PCI," "immediate PCI," "rescue PCI," "deferred PCI," "facilitated PCI," and the "pharmacoinvasive strategy" have evolved in parallel with advances in antithrombotic therapy and STEMI prehospital and hospital systems of care. The clinical challenge in primary PCI is achieving rapid time to treatment and increasing patient access to this preferred reperfusion strategy. The clinical challenge in patients treated with fibrinolytic therapy is deciding for whom and when to perform coronary angiography.

In unstable patients (e.g., severe heart failure or cardiogenic shock, hemodynamically compromising ventricular arrhythmias) not treated initially with primary PCI, a strategy of immediate coronary angiography with intent to perform PCI is implemented unless invasive management is considered futile or unsuitable given the clinical circumstances (383,384).

In stable patients treated with fibrinolytic therapy and clinical suspicion of reperfusion failure, a strategy of immediate coronary angiography followed by PCI improves outcome in those at high risk (385,386). Such a strategy is also implemented in patients with evidence for infarct artery reocclusion (Table 9). The clinical diagnosis of failed

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fibrinolysis is difficult but is best made when there is <50% ST-segment resolution 90 minutes after initiation of therapy in the lead showing the greatest degree of ST-segment elevation at presentation. Given the association between bleeding events and adverse cardiac events, a reasonable approach is to select moderate- and high-risk patients for PCI and treat low-risk patients with medical therapy. ECG and clinical findings of anterior MI or inferior MI with right ventricular involvement or precordial ST-segment depression, as well as ongoing pain, usually predicts increased risk and the greatest potential benefit (392). Conversely, patients with symptom resolution, improving ST-segment elevation, or inferior MI localized to 3 ECG leads probably gain little benefit.

In stable patients treated with fibrinolytic therapy and clinical evidence for successful reperfusion, an early invasive strategy with cardiac catheterization performed within 24 hours decreases reinfarction and recurrent ischemic events (388,390,391). Because of the associated increased bleeding risk, very early (<2 to 3 hours) catheterization after administration of fibrinolytic therapy with intent to perform revascularization should be reserved for patients with evidence of failed fibrinolysis and significant myocardial jeopardy for whom immediate angiography and revascularization would be appropriate (393).

5.2.2.2. PRIMARY PCI OF THE INFARCT ARTERY: RECOMMENDATIONS

CLASS I

1. Primary PCI should be performed in patients within 12 hours of onset of STEMI (379–382). *(Level of Evidence: A)*
2. Primary PCI should be performed in patients with STEMI presenting to a hospital with PCI capability within 90 minutes of first medical contact as a systems goal (394,395). *(Level of Evidence: B)*
3. Primary PCI should be performed in patients with STEMI presenting to a hospital without PCI capability within 120 minutes of first medical contact as a systems goal (396–398). *(Level of Evidence: B)*
4. Primary PCI should be performed in patients with STEMI who develop severe heart failure or cardiogenic shock and are suitable candidates for revascularization as soon as possible, irrespective of time delay (383,384). *(Level of Evidence: B)*
5. Primary PCI should be performed as soon as possible in patients with STEMI and contraindications to fibrinolytic therapy with ischemic symptoms for less than 12 hours (399,400). *(Level of Evidence: B)*

CLASS IIa

1. Primary PCI is reasonable in patients with STEMI if there is clinical and/or electrocardiographic evidence of ongoing ischemia between 12 and 24 hours after symptom onset (401–403). *(Level of Evidence: B)*

CLASS IIb

1. Primary PCI might be considered in asymptomatic patients with STEMI and higher risk presenting between 12 and 24 hours after symptom onset. *(Level of Evidence: C)*

CLASS III: HARM

1. PCI should not be performed in a noninfarct artery at the time of primary PCI in patients with STEMI without hemodynamic compromise (404–408). *(Level of Evidence: B)*

Primary PCI is preferred to fibrinolytic therapy when time-to-treatment delays are short and the patient presents to a high-volume, well-equipped center staffed with expert interventional cardiologists and skilled support staff. Compared with fibrinolytic therapy in RCTs, primary PCI produces higher rates for infarct artery patency, TIMI flow grade 3, and lower rates for recurrent ischemia, reinfarction, emergency repeat revascularization procedures, intracranial hemorrhage, and death (379). Early, successful PCI also greatly decreases the complications of STEMI that result from longer ischemic times or unsuccessful fibrinolytic therapy, allowing earlier hospital discharge and resumption of daily activities. The greatest mortality benefit of primary PCI is in high-risk patients. PCI outcomes may not be as successful with prolonged time-to-treatment or low-volume hospitals and operators (Table 10).

Several reports have shown excellent outcomes for patients with STEMI undergoing interhospital transfer where first medical contact–to-door balloon time modestly exceeded the systematic goal of <90 minutes (396–398,409). In these reports, the referring hospital and the receiving hospital established a transfer protocol that minimized transfer delays, and outcomes were similar to those of direct-admission patients. On the basis of these results, the PCI and STEMI guideline writing committees have modified the first medical contact–to-device time goal from 90 minutes to 120 minutes for interhospital transfer patients (397), while emphasizing that systems should continue to strive for times ≤90 minutes. Hospitals that cannot meet these criteria should use fibrinolytic therapy as their primary reperfusion strategy.

PCI of a noninfarct artery at the time of primary PCI in stable patients is associated with worse clinical outcomes unless the patient is in cardiogenic shock where PCI of a severe stenosis in a coronary artery supplying a large territory of myocardium might improve hemodynamic stability (404,406,408). Delayed PCI can be performed in noninfarct arteries at a later time if clinically indicated (410–412).

5.2.2.3. DELAYED OR ELECTIVE PCI IN PATIENTS WITH STEMI: RECOMMENDATIONS

CLASS IIa

1. PCI is reasonable in patients with STEMI and clinical evidence for fibrinolytic failure or infarct artery reocclusion (385,386). *(Level of Evidence: B)*
2. PCI is reasonable in patients with STEMI and a patent infarct artery 3 to 24 hours after fibrinolytic therapy (390,391). *(Level of Evidence: B)*
3. PCI is reasonable in patients with STEMI who demonstrate ischemia on noninvasive testing (410,411). *(Level of Evidence: B)*

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Table 10. Indications for PCI in STEMI

Indications	COR	LOE	References
Primary PCI*			
STEMI symptoms within 12 h	I	A	(379–382)
Severe heart failure or cardiogenic shock	I	B	(383,384)
Contraindications to fibrinolytic therapy with ischemic symptoms <12 h	I	B	(399,400)
Clinical and/or electrocardiographic evidence of ongoing ischemia between 12 and 24 h after symptom onset	IIa	B	(401–403)
Asymptomatic patients presenting between 12 and 24 h after symptom onset and higher risk	IIb	C	N/A
Noninfarct artery PCI at the time of primary PCI in patients without hemodynamic compromise	III: Harm	B	(404–408)
Delayed or elective PCI in patients with STEMI			
Clinical evidence for fibrinolytic failure or infarct artery reocclusion	IIa	B	(385,386)
Patent infarct artery 3 to 24 h after fibrinolytic therapy	IIa	B	(390,391)
Ischemia on noninvasive testing	IIa	B	(410,411)
Hemodynamically significant stenosis in a patent infarct artery >24 h after STEMI	IIb	B	(413–417)
Totally occluded infarct artery >24 h after STEMI in a hemodynamically stable asymptomatic patient without evidence of severe ischemia	III: No Benefit	B	(418–420)

*Systems goal of performing primary PCI within 90 min of first medical contact when the patient presents to a hospital with PCI capability (394,395) (*Class I; LOE: B*) and within 120 min when the patient presents to a hospital without PCI capability (396–398) (*Class I; LOE: B*).

COR indicates class of recommendation; LOE, level of evidence; N/A, not applicable; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

CLASS IIb

1. PCI of a hemodynamically significant stenosis in a patent infarct artery greater than 24 hours after STEMI may be considered as part of an invasive strategy (413–417). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. PCI of a totally occluded infarct artery greater than 24 hours after STEMI should not be performed in asymptomatic patients with 1- or 2-vessel disease if patients are hemodynamically and electrically stable and do not have evidence of severe ischemia (418–420). *(Level of Evidence: B)*

Studies and meta-analyses suggest potential benefit for PCI in fibrinolytic failure (385,386). In stable patients treated with fibrinolytic therapy and clinical evidence for successful reperfusion, an early invasive strategy with cardiac catheterization performed within 24 hours decreases reinfarction and recurrent ischemic events (388,390,391).

PCI for a hemodynamically significant stenosis in a patent infarct artery >24 hours after STEMI as part of a revascularization strategy improves outcome (410,411,413–417). PCI of an occluded infarct artery 1 to 28 days after MI in asymptomatic patients without evidence of myocardial ischemia has no incremental benefit beyond optimal medical therapy with aspirin, beta blockers, angiotensin-converting enzyme inhibitors, and statins in preserving LV function and preventing subsequent cardiovascular events (418–420). It is important to note that elective PCI of an occluded infarct artery has not been studied in patients with New York Heart Association functional class III or IV heart failure, rest angina, serum creatinine >2.5 mg/dL, left main or 3-vessel CAD, clinical instability, or severe inducible ischemia on stress testing in an infarct zone that is not akinetic or dyskinetic.

5.2.3. Cardiogenic Shock: Recommendations

CLASS I

1. PCI is recommended for patients with acute MI who develop cardiogenic shock and are suitable candidates (384,421–423). *(Level of Evidence: B)*
2. A hemodynamic support device is recommended for patients with cardiogenic shock after STEMI who do not quickly stabilize with pharmacological therapy (384,424–427). *(Level of Evidence: B)*

See Online Data Supplement 22 for additional data regarding cardiogenic shock.

Cardiogenic shock is the leading cause of in-hospital mortality complicating STEMI. Revascularization is the only treatment proven to decrease mortality rates (384,421–423). Although revascularization is almost always accomplished through PCI, selected patients with severe 3-vessel or left main disease can benefit from emergency CABG. Revascularization attempts may be futile and not indicated in cases of severe multiorgan failure (427). Patient selection for revascularization is more important in the elderly, but several observational reports demonstrate acceptable outcomes in patients with few comorbidities and a reasonable potential for survival (428–431). Patients who present to hospitals without PCI capability are usually emergently transported to a PCI center, because mortality without transfer is markedly elevated (432).

5.2.3.1. PROCEDURAL CONSIDERATIONS FOR CARDIOGENIC SHOCK

Patients with cardiogenic shock should receive standard pharmacological therapies, including aspirin, a $P2Y_{12}$ receptor antagonist, and anticoagulation (427,433). Inotropic and vasopressor therapy improves perfusion pressure. Historically, negative inotropes and vasodilators are avoided. IV

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GP IIb/IIIa inhibitors have been shown to provide benefit in observational studies but not in 1 small RCT (433).

Endotracheal intubation and mechanical ventilation with positive end-expiratory pressure is usually necessary in patients with respiratory failure. Placement of a temporary pacemaker is indicated for patients with bradycardia or high-degree atrioventricular heart block. A pulmonary artery catheter can provide information to dose and titrate inotropes and pressors. Further hemodynamic support is available with IABP counterpulsation or percutaneous LV assist devices, although no data support a reduction in mortality rates (434).

Contrast medium injections should be minimized. Orthogonal angiograms of the left coronary artery and a left anterior oblique angiogram of the right coronary artery are usually sufficient to identify the infarct artery (435). Although most patients undergoing revascularization will receive a stent as part of the procedure, there are conflicting data on the impact of stenting over balloon angioplasty. Some studies reveal lower mortality rates (436–438), whereas others reveal no benefit (439) or higher mortality rates (440). There are no data comparing the choice of BMS versus DES in cardiogenic shock; however, BMS are often used because compliance with long-term DAPT is often unclear in the emergency setting.

In patients with multivessel disease, revascularization of the noninfarct artery may be necessary to maximize myocardial perfusion. Alternatively, in patients with multivessel disease and particularly left main disease, emergency CABG as a primary reperfusion strategy may be preferred (50,441). Refractory cardiogenic shock unresponsive to revascularization may necessitate institution of more intensive cardiac support with a ventricular assist device or other hemodynamic support devices to allow for myocardial recovery or subsequent cardiac transplantation in suitable patients.

5.2.4. Revascularization Before Noncardiac Surgery: Recommendations

CLASS IIa

1. For patients who require PCI and are scheduled for elective noncardiac surgery in the subsequent 12 months, a strategy of balloon angioplasty, or BMS implantation followed by 4 to 6 weeks of DAPT, is reasonable (442–448). *(Level of Evidence: B)*
2. For patients with DES who must undergo urgent surgical procedures that mandate the discontinuation of DAPT, it is reasonable to continue aspirin if possible and restart the $P2Y_{12}$ inhibitor as soon as possible in the immediate postoperative period (444). *(Level of Evidence: C)*

CLASS III: HARM

1. Routine prophylactic coronary revascularization should not be performed in patients with stable CAD before noncardiac surgery (449,450). *(Level of Evidence: B)*
2. Elective noncardiac surgery should not be performed in the 4 to 6 weeks after balloon angioplasty or BMS implantation or the 12 months after DES implantation in patients in whom the $P2Y_{12}$ inhibitor will need to be discontinued perioperatively (208,447, 451,452). *(Level of Evidence: B)*

The 2007 and 2009 ACC/AHA Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery gave detailed recommendations for the evaluation of patients undergoing noncardiac surgery (444). Patients with evidence of ACS should receive standard therapy, including early revascularization, to minimize the risk of adverse events. Patients with known significant left main or 3-vessel CAD who would otherwise benefit from revascularization in terms of survival or symptomatic relief also generally undergo revascularization before elective noncardiac surgery.

Two RCTs (449,450) found no benefit with routine preoperative revascularization before noncardiac surgery. Noncardiac surgery early after coronary stenting, particularly in the first 4 weeks, is associated with a high risk of stent thrombosis and death (444,446,448). When emergency surgery is necessary, the patient should proceed to surgery without prior PCI. When surgery is required within 30 days and coronary revascularization is required before surgery, many clinicians perform balloon angioplasty alone to avoid the need for DAPT. In situations where preoperative revascularization is required and surgery can be deferred for at least 30 days, many clinicians use BMS and discontinue DAPT after 30 days. If surgery is elective and can be deferred for 1 year, most clinicians would consider DES to reduce the long-term risk of restenosis. A dilemma occurs when a patient has undergone PCI and then unexpectedly requires noncardiac surgery. Many patients can undergo surgery on DAPT, where the risk-benefit ratio will favor continued dual antiplatelet inhibition. If it is necessary to hold $P2Y_{12}$ inhibitor therapy, most clinicians will still continue aspirin uninterrupted during the perioperative period if the bleeding risk is not prohibitive. When the risk of delaying surgery or performing surgery while the patient is on DAPT exceeds the risk of stent thrombosis from stopping DAPT, the $P2Y_{12}$ inhibitor is stopped before surgery and resumed as soon as possible afterward. No $P2Y_{12}$ inhibitor "bridging" strategy (e.g., GP IIb/IIIa inhibitor, antithrombin therapy) has been validated.

5.3. Coronary Stents: Recommendations

CLASS I

1. Before implantation of DES, the interventional cardiologist should discuss with the patient the need for and duration of DAPT and the ability of the patient to comply with and tolerate DAPT (212). *(Level of Evidence: C)*
2. DES are useful as an alternative to BMS to reduce the risk of restenosis in cases in which the risk of restenosis is increased and the patient is likely to be able to tolerate and comply with prolonged DAPT *(Level of Evidence: A for elective PCI* [453,453a,454–456]*; Level of Evidence: C for UA/NSTEMI* (453)*; Level of Evidence: A for STEMI* [453,456–459]).
3. Balloon angioplasty or BMS should be used in patients with high bleeding risk, inability to comply with 12 months of DAPT, or anticipated invasive or surgical procedures within the next 12 months, during which time DAPT may be interrupted (208,460–462). *(Level of Evidence: B)*

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CLASS III: HARM

1. **PCI with coronary stenting should not be performed if the patient is not likely to be able to tolerate and comply with DAPT (208–211). *(Level of Evidence: B)***
2. **DES should not be implanted if the patient is not likely to be able to tolerate and comply with prolonged DAPT or this cannot be determined before stent implantation (208,460–462). *(Level of Evidence: B)***

Coronary stent implantation is commonly performed during PCI to prevent recoil, abrupt closure, and late restenosis (463,464). BMS are composed of either stainless steel or cobalt chromium alloys. Because the risk of stent thrombosis is greatest within the first 30 days after implantation, the use of DAPT is required for 30 days after implantation of BMS (208).

In the United States, 4 types of DES are currently approved: sirolimus-eluting stents, paclitaxel-eluting stents, zotarolimus-eluting stents, and everolimus-eluting stents. DES vary according to stent scaffold material and design, drug content, and the polymer used for drug elution; however, several common clinical features are present. First, sirolimus-eluting stents, paclitaxel-eluting stents, and zotarolimus-eluting stents have been demonstrated in RCTs to be associated with a reduced need for repeat revascularization and no increase in death or MI compared with BMS at 4 years' follow-up (465). Everolimus-eluting stents have been demonstrated in RCTs to be associated with a lower need for repeat revascularization than paclitaxel-eluting stents, and, by inference, a lower risk for repeat revascularization than BMS (466,467), with no increase in death or MI at 2-year follow-up (468). Second, each of these stents is presumed to be associated with delayed healing based on pathologic studies and longer periods of risk for thrombosis compared with BMS and require longer duration of DAPT (469). In the RCTs that led to the U.S. Food and Drug Administration (FDA) approval of these stents, the recommended minimum duration of DAPT therapy was 3 to 6 months. Recently, the consensus of clinical practice has been 12 months of DAPT following DES implantation to avoid late (after 30 days) thrombosis (208), based on observational studies of paclitaxel-eluting stents and sirolimus-eluting stents that indicate lower risk of late stent thrombosis with >6 months of therapy (212). Extending DAPT beyond 1 year is considered reasonable by some practitioners based on observational data analysis (212), but RCTs to determine whether longer DAPT is associated with reduction in stent thrombosis risk have not been completed. Finally, DES therapy is more expensive than BMS. Cost-effectiveness analysis has shown a reduction in total cost associated with DES because of avoidance of repeat procedures, yet it may be reasonable to consider use of BMS in patient subsets in which the risk of restenosis is low (470).

This risk-benefit profile is most favorable for DES over BMS when the risk of restenosis with BMS is high (Table 11). Pooled and meta-analyses have demonstrated that in patients with diabetes, use of DES decreases the risk of restenosis compared with BMS (471,472). DES may be more appealing for unprotected left main PCI, given the rate and clinical consequences of restenosis in this location (473–475). The risk of stent thrombosis is higher in populations or lesion types excluded from RCTs of DES (e.g., STEMI, smaller arteries [<2.5 mm diameter], longer lesions, bifurcations) (210,465). Importantly, these features also predict both stent thrombosis (476) and restenosis in BMS (477). The greatest risk of stent thrombosis is within the first year, ranging from 0.7% to 2.0%, depending on patient and lesion complexity. Late stent thrombosis risk after 1 year with DES is observed at a rate of 0.2% to 0.4% per year (210,478).

Table 11. Clinical Situations Associated With DES or BMS Selection Preference

DES Generally Preferred Over BMS (Efficacy Considerations)	BMS Preferred Over DES (Safety Considerations)
• Left main disease • Small vessels • In-stent restenosis • Bifurcations • Diabetes • Long lesions • Multiple lesions • Saphenous vein grafts	• Unable to tolerate or comply with DAPT • Anticipated surgery requiring discontinuation of DAPT within 12 mo • High risk of bleeding

BMS indicates bare-metal stent(s); DAPT, dual antiplatelet therapy; and DES, drug-eluting stent(s).

Compared with balloon angioplasty, routine BMS implantation during primary PCI decreases risk for target-vessel revascularization and possibly reduces MI rates but does not reduce mortality rates (479). More recent primary PCI studies and meta-analyses have demonstrated lower restenosis rates without increased risk of adverse stent outcome with DES compared with BMS. Although stent thrombosis rates in trials of STEMI are higher than in trials of elective PCI, the rates of stent thrombosis are not higher with DES compared with BMS in STEMI (453,456–459).

The greatest risk for DES thrombosis is early discontinuation of DAPT (208,460–462). It is therefore important to determine that the patient will likely be able to tolerate and comply with DAPT before implantation of DES. Therefore, DES should not be used in the presence of financial barriers to continuing prolonged DAPT, social barriers that may limit patient compliance, or medical issues involving bleeding risks or the need for invasive or surgical procedures in the following year that would interrupt antiplatelet therapy. The need for use of long-term warfarin and the associated increased risk of bleeding with long-term "triple therapy" is also a consideration in deciding on DES versus BMS (480).

Patients implanted with most contemporary coronary stents can undergo magnetic resonance imaging (MRI) examination any time after implantation (481,482). The effect of the MRI examination on heating of the drug or polymer coating used in DES is unknown. There is no

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indication for antibiotic prophylaxis before dental or invasive procedures in patients with coronary stents (483).

5.4. Adjunctive Diagnostic Devices

5.4.1. FFR: Recommendation

CLASS IIa

1. FFR is reasonable to assess angiographic intermediate coronary lesions (50% to 70% diameter stenosis) and can be useful for guiding revascularization decisions in patients with SIHD (12,97, 484–486). *(Level of Evidence: A)*

See Online Data Supplement 23 for additional data regarding FFR.

The limitations of coronary angiography for determination of lesion severity have been well described. Angiography may under- or overestimate lesion stenosis. Various physiologic measurements can be made in the catheterization laboratory, including coronary flow reserve and FFR. The correlation of ischemia on stress testing with FFR values of <0.75 has been established in numerous comparative studies with high sensitivity (88%), specificity (100%), positive predictive value (100%), and overall accuracy (93%) (487). The 5-year outcomes for patients with medical therapy based on an FFR >0.75 were superior compared with PCI in the DEFER (Deferral Versus Performance of Balloon Angioplasty in Patients Without Documented Ischemia) study (485). The FAME (Fractional Flow Reserve Versus Angiography for Multivessel Evaluation) study identified the benefit for deferring PCI in patients with multivessel disease and lesion FFR >0.80, with reduced rates of cardiac events at both 1 and 2 years (97,486). Whereas both FFR and IVUS have been used for assessment of intermediate angiographic stenosis with favorable outcomes, FFR may reduce the need for revascularization when compared with IVUS (488). Although IVUS is often considered in the assessment of equivocal left main stenosis, FFR may be similarly effective (484).

5.4.2. IVUS: Recommendations

CLASS IIa

1. IVUS is reasonable for the assessment of angiographically indeterminant left main CAD (489–491). *(Level of Evidence: B)*
2. IVUS and coronary angiography are reasonable 4 to 6 weeks and 1 year after cardiac transplantation to exclude donor CAD, detect rapidly progressive cardiac allograft vasculopathy, and provide prognostic information (492–494). *(Level of Evidence: B)*
3. IVUS is reasonable to determine the mechanism of stent restenosis (495). *(Level of Evidence: C)*

CLASS IIb

1. IVUS may be reasonable for the assessment of non–left main coronary arteries with angiographically intermediate coronary stenoses (50% to 70% diameter stenosis) (489,496,497). *(Level of Evidence: B)*
2. IVUS may be considered for guidance of coronary stent implantation, particularly in cases of left main coronary artery stenting (490,495,498). *(Level of Evidence: B)*
3. IVUS may be reasonable to determine the mechanism of stent thrombosis (495). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. IVUS for routine lesion assessment is not recommended when revascularization with PCI or CABG is not being contemplated. *(Level of Evidence: C)*

IVUS provides a unique coronary artery assessment of lesion characteristics, minimal and maximal lumen diameters, cross-sectional area, and plaque area. Diagnostic uses for IVUS include the assessment of angiographic indeterminant coronary artery stenoses, determination of the mechanism of stent restenosis or thrombosis, and postcardiac transplantation surveillance of CAD (488,490–492,499). For left main coronary artery stenoses, a minimal lumen diameter of <2.8 mm or a minimal lumen area of <6 mm^2 suggests a physiologically significant lesion for which patients may benefit from revascularization. A minimal lumen area >7.5 mm^2 suggests that revascularization may be safely deferred (490). A minimal lumen area between 6 and 7.5 mm^2 requires further physiological assessment, such as measurement of FFR (487,500). For non–left main stenoses, minimal lumen diameter >2.0 mm and minimal lumen area >4.0 mm^2 correlate with low event rates (489). However, in smaller-diameter arteries (minimal lumen area <3.0 mm^2), measurement of FFR may more accurately reflect a significant stenosis (488). Studies correlating IVUS measures with ischemia have not specified the size of coronary arteries for which such correlations are valid (488,489,497).

IVUS assessment after stent thrombosis may serve to identify stent underexpansion or malapposition (499). IVUS is superior to angiography in the early detection of the diffuse, immune-mediated, cardiac allograft vasculopathy; recommendations about the use of IVUS for this purpose were published in 2010 by the International Society of Heart and Lung Transplantation (492). Whereas IVUS has been an important research tool in interventional cardiology, most clinical studies of IVUS have not been able to demonstrate that its routine use results in a reduction of MACE or restenosis rates (498,501,502). IVUS has been inappropriately used in clinical practice to justify implanting stents in mildly diseased segments that may require no intervention (503).

5.4.3. Optical Coherence Tomography

Compared with IVUS, optical coherence tomography has greater resolution (10 to 20 micronmeter axially) but more limited depth of imaging (1 to 1.5 mm) (504,505). Unlike IVUS, optical coherence tomography requires that the artery be perfused with saline solution or crystalloid during image acquisition and therefore does not permit imaging of ostial lesions. Clinical studies have shown low optical coherence tomography complication rates (506,507), similar to those of IVUS (508). The excellent resolution of optical coherence tomography permits detailed in vivo 2-dimensional imaging of plaque morphological characteristics (e.g., calcification, lipid,

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thrombus, fibrous cap thickness, and plaque ulceration or rupture) (508–510) and evaluation of the arterial response to stent implantation (e.g., stent strut neointimal thickness and apposition) (511–513) and may be of value in clinical research. The appropriate role for optical coherence tomography in routine clinical decision making has not been established.

5.5. Adjunctive Therapeutic Devices

5.5.1. Coronary Atherectomy: Recommendations

CLASS IIa

1. Rotational atherectomy is reasonable for fibrotic or heavily calcified lesions that might not be crossed by a balloon catheter or adequately dilated before stent implantation (514,515). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. Rotational atherectomy should not be performed routinely for de novo lesions or in-stent restenosis (516–519). *(Level of Evidence: A)*

Rotational atherectomy in RCTs was associated with higher rates of MACE at 30 days and no reduction in restenosis. It has a limited role in facilitating the dilation or stenting of lesions that cannot be crossed or expanded with PCI (520,521). Devices for directional coronary atherectomy are no longer marketed in the United States.

5.5.2. Thrombectomy: Recommendation

CLASS IIa

1. Aspiration thrombectomy is reasonable for patients undergoing primary PCI (522–524). *(Level of Evidence: B)*

The benefit of thrombectomy in patients with STEMI appears to be dependent on the type of thrombectomy technique used (522–526). No clinical benefit for routine rheolytic thrombectomy (AngioJet device, MEDRAD Interventional, Minneapolis, MN and Pittsburgh, PA) has been demonstrated in primary PCI (524–526). Two RCTs (522,523) and a meta-analysis (524) support the use of manual aspiration thrombectomy during primary PCI to improve microvascular reperfusion and decrease MACE. It is not known whether a strategy of selective thrombus aspiration in patients with a large thrombus burden might be equivalent to routine thrombus aspiration.

5.5.3. Laser Angioplasty: Recommendations

CLASS IIb

1. Laser angioplasty might be considered for fibrotic or moderately calcified lesions that cannot be crossed or dilated with conventional balloon angioplasty (527). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. Laser angioplasty should not be used routinely during PCI (516,518,528). *(Level of Evidence: A)*

RCTs of laser angioplasty have not demonstrated improved clinical or angiographic PCI outcomes, although some practitioners think that laser angioplasty may be of use in the treatment of lesions that are difficult to dilate with balloon angioplasty (527).

5.5.4. Cutting Balloon Angioplasty: Recommendations

CLASS IIb

1. Cutting balloon angioplasty might be considered to avoid slippage-induced coronary artery trauma during PCI for in-stent restenosis or ostial lesions in side branches (529). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. Cutting balloon angioplasty should not be performed routinely during PCI (516,529,530). *(Level of Evidence: A)*

Although some small, single-center trials have suggested that cutting balloon angioplasty was more efficacious than balloon angioplasty, it was not found to be safer or more effective in several large trials (516,529,531). When balloon dilation is required for in-stent restenosis, however, cutting balloons are less likely to slip and may offer a technical advantage over conventional balloons (529). Scoring balloons have been used by some cardiologists as an alternative to cutting balloons, but no RCTs have been reported (531).

5.5.5. Embolic Protection Devices: Recommendation

CLASS I

1. Embolic protection devices (EPDs) should be used during saphenous vein graft (SVG) PCI when technically feasible (532–535). *(Level of Evidence: B)*

The incidence of MACE doubles in SVG PCI compared with native-artery PCI (536). A distal balloon occlusion EPD decreased the 30-day composite outcome of death, MI, emergency CABG, or target-lesion revascularization (9.6% versus 16.5%) in the only RCT (532). Subsequent noninferiority comparisons have demonstrated similar benefit with proximal occlusion and distal filter EPDs, with benefit limited to reduction in periprocedural MI (534,535) (Section 5.10). Distal EPDs do not improve survival or reinfarction rates in patients undergoing native-artery PCI (524,537).

5.6. Percutaneous Hemodynamic Support Devices: Recommendation

CLASS IIb

1. Elective insertion of an appropriate hemodynamic support device as an adjunct to PCI may be reasonable in carefully selected high-risk patients. *(Level of Evidence: C)*

IABP counterpulsation is frequently used as an adjunct to PCI in hemodynamically unstable patients (538,539). In single-center series, the routine prophylactic use of IABP during PCI in high-risk patients was associated with lower mortality and fewer major complications compared with rescue use of IABP (540,541). In the only RCT in high-risk PCI patients (BCIS-1 [Balloon Pump-Assisted Coronary Intervention Study]) (542), there was no difference in the primary composite outcome between routine and provisional use of IABP. There were also no differences in major secondary endpoints except major procedural complications (e.g., prolonged hypotension, ventricular tachycardia/fibrillation, cardiopulmonary arrest), which were lower in the

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routine IABP group. Bleeding and access site complication rates tended to be higher in the routine IABP group. The "bailout" rate of IABP insertion in the provisional IABP group was 12%, mostly for procedural hypotension (542). A meta-analysis of IABP therapy in patients with STEMI did not show improved outcomes with the use of IABP (434).

The Impella Recover LP 2.5 System (Abiomed, Aachen, Germany/Danvers, Massachusetts) is a 12.5 Fr catheter that is inserted percutaneously through a 13 Fr femoral artery sheath and placed across the aortic valve into the left ventricle, through which a transaxial blood pump provides flows of up to 2.5 L/min. This has been used in patients with cardiogenic shock (543,544) as well as elective PCI (545). The hemodynamic effects of the Impella 2.5 have been studied in high-risk PCI patients, demonstrating beneficial LV unloading effect (decreased end-diastolic pressure and wall stress) with no change in global or systolic LV function (546). The PROTECT I (A Prospective Feasibility Trial Investigating the Use of the IMPELLA Recover LP 2.5 System in Patients Undergoing High-Risk PCI) trial in 20 patients undergoing high-risk PCI with the Impella 2.5 system concluded that this device was safe, easy to implant, and hemodynamically effective (547). The Europella Registry included 144 patients undergoing high-risk PCI and reported the safety, feasibility, and potential usefulness of the device and that RCTs were warranted (548). The randomized PROTECT II (A Prospective, Multicenter, Randomized Controlled Trial of the IMPELLA Recover LP 2.5 System Versus Intra Aortic Balloon Pump in Patients Undergoing Non Emergent High Risk PCI) trial, which was designed to demonstrate superiority of Impella over IABP in terms of 1-month adverse events, was halted for futility after interim analysis of study results (549).

The TandemHeart (CardiacAssist, Inc, Pittsburgh, PA) is a left atrial to aorta catheter-based system that includes a centrifugal blood pump providing flows of up to 4 L/min. This device uses a 21 Fr cannula percutaneously inserted into the femoral vein for transseptal access of the left atrium with a 15 Fr catheter placed in the contralateral femoral artery and positioned above the aortic bifurcation. An extracorporeal pump then returns oxygenated blood from the left atrium to the arterial system, thereby unloading the left ventricle (550,551). The hemodynamic effects have been studied in patients undergoing high-risk PCI (552). Several small studies have addressed the clinical efficacy of the TandemHeart in high-risk patients undergoing PCI (551,553–556). In a single-center report of 68 patients undergoing high-risk PCI using either TandemHeart or Impella Recover 2.5, success rates (>90%) and vascular complications (7%) were similar (553).

High-risk patients may include those undergoing unprotected left main or last-remaining-conduit PCI, those with severely depressed EF undergoing PCI of a vessel supplying a large territory, and/or those with cardiogenic shock. Patient risk, hemodynamic support, ease of application/removal, and operator and laboratory expertise are all factors involved in consideration of use of these devices. With devices that require large cannula insertion, the risk of vascular injury and related complications are important considerations regarding necessity and choice of device.

5.7. Interventional Pharmacotherapy

5.7.1. Procedural Sedation

The term *conscious sedation* is falling out of favor with the recognition that there is a spectrum of procedural sedation levels. Most patients undergoing PCI fall under the definition of either minimal sedation (anxiolysis) or moderate sedation (depressed consciousness with the ability to respond purposefully to verbal commands) (557). Nonetheless, an underlying principle of procedural sedation is that the physician should be prepared to manage one level of sedation deeper than the level intended. Thus, cardiologists should be cognizant of the principles of managing deep sedation (depressed consciousness without easy arousal that may require assistance in maintaining airway patency or spontaneous ventilation).

A full review of procedural sedation is beyond the scope of this document, but practice guidelines for sedation and analgesia by nonanesthesiologists, along with The Joint Commission standards, provides a reasonable framework. These guidelines outline several general principles (558,559). Before the procedure the patient should be assessed for predictors of difficult intubation or a history of prior difficult intubation. The patient should be monitored by someone dedicated to observing the level and effects of sedation. Level of consciousness, respiratory rate, blood pressure, cardiac rhythm, and oxygen saturation by pulse oximetry should be monitored. Available equipment should include a high-flow oxygen source, suction, airway management equipment, a defibrillator, resuscitation drugs, and reversal agents appropriate for the drugs being used. A free-flowing IV line should be established. Supplemental oxygen is usually administered, even in the absence of preexisting hypoxia, to provide a margin of safety.

Agents used for sedation are best given in incremental doses, allowing adequate time for the development and assessment of peak effect. The most commonly used agents are listed in Appendix 4F.

5.7.2. Oral Antiplatelet Therapy: Recommendations

CLASS I

1. Patients already taking daily aspirin therapy should take 81 mg to 325 mg before PCI (301–304). *(Level of Evidence: B)*
2. Patients not on aspirin therapy should be given nonenteric aspirin 325 mg before PCI (301,303,304). *(Level of Evidence: B)*
3. After PCI, use of aspirin should be continued indefinitely (560–563). *(Level of Evidence: A)*
4. A loading dose of a $P2Y_{12}$ receptor inhibitor should be given to patients undergoing PCI with stenting (564–568) *(Level of Evidence: A)*. Options include

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a. Clopidogrel 600 mg (ACS and non-ACS patients) (564–566) *(Level of Evidence: B)*
b. Prasugrel 60 mg (ACS patients) (567) *(Level of Evidence: B)*
c. Ticagrelor 180 mg (ACS patients) (568) *(Level of Evidence: B)*

5. The loading dose of clopidogrel for patients undergoing PCI after fibrinolytic therapy should be 300 mg within 24 hours and 600 mg more than 24 hours after receiving fibrinolytic therapy (565,569). *(Level of Evidence: C)*
6. Patients should be counseled on the need for and risks of DAPT before placement of intracoronary stents, especially DES, and alternative therapies should be pursued if patients are unwilling or unable to comply with the recommended duration of DAPT (208). *(Level of Evidence: C)*
7. The duration of $P2Y_{12}$ inhibitor therapy after stent implantation should generally be as follows:
   a. In patients receiving a stent (BMS or DES) during PCI for ACS, $P2Y_{12}$ inhibitor therapy should be given for at least 12 months. Options include clopidogrel 75 mg daily (570), prasugrel 10 mg daily (567), and ticagrelor 90 mg twice daily (568). *(Level of Evidence: B)*
   b. In patients receiving DES for a non-ACS indication, clopidogrel 75 mg daily should be given for at least 12 months if patients are not at high risk of bleeding (208,212,571). *(Level of Evidence: B)*
   c. In patients receiving BMS for a non-ACS indication, clopidogrel should be given for a minimum of 1 month and ideally up to 12 months (unless the patient is at increased risk of bleeding; then it should be given for a minimum of 2 weeks) (208,572). *(Level of Evidence: B)*

CLASS IIa

1. After PCI, it is reasonable to use aspirin 81 mg per day in preference to higher maintenance doses (302,573–576). *(Level of Evidence: B)*
2. If the risk of morbidity from bleeding outweighs the anticipated benefit afforded by a recommended duration of $P2Y_{12}$ inhibitor therapy after stent implantation, earlier discontinuation (e.g., <12 months) of $P2Y_{12}$ inhibitor therapy is reasonable. *(Level of Evidence: C)*

CLASS IIb

1. Continuation of DAPT beyond 12 months may be considered in patients undergoing DES implantation (567,568). *(Level of Evidence: C)*

CLASS III: HARM

1. Prasugrel should not be administered to patients with a prior history of stroke or transient ischemic attack (567). *(Level of Evidence: B)*

Aspirin reduces the frequency of ischemic complications after PCI. Although the minimum effective aspirin dosage in the setting of PCI has not been established, aspirin 325 mg given at least 2 hours, and preferably 24 hours, before PCI is recommended (302,303), after which aspirin 81 mg daily should be continued indefinitely.

Several investigations have explored various loading doses of clopidogrel before or during PCI. Compared with a 300-mg loading dose, doses of either 600 mg or 900 mg achieve greater degrees of platelet inhibition with fewer low responders (577). A meta-analysis of 7 studies that included 25,383 patients undergoing PCI demonstrated that intensified loading of clopidogrel with 600 mg reduces the rate of MACE without an increase in major bleeding compared with 300 mg (578). Another study suggested that a 600-mg loading dose of clopidogrel is associated with improvements in procedural angiographic endpoints and 1-year clinical outcomes in patients with STEMI who undergo primary PCI compared with a 300-mg dose (579). There is no benefit with increasing the loading dose to 900 mg compared with 600 mg (577). Clopidogrel 75 mg daily should be given for a minimum of 4 weeks after balloon angioplasty or BMS implantation (a minimum of 2 weeks if increased bleeding risk is present) (580) and for at least 12 months after DES implantation (unless the risk of bleeding outweighs the anticipated benefit). Patients should be counseled on the need for and risks of DAPT before stent implantation, especially DES implantation, and alternative therapies pursued (BMS or balloon angioplasty) if they are unwilling or unable to comply with the recommended duration of DAPT.

The efficacy of clopidogrel pretreatment remains controversial. Although some studies have suggested that pretreatment with clopidogrel is associated with decreased platelet aggregation and a significantly lower incidence of periprocedural MI after elective PCI, others have suggested no benefit to pretreatment compared with administration of the drug in the catheterization laboratory (572,581,582).

When prasugrel was compared with clopidogrel in patients with ACS in TRITON–TIMI 38 (Trial to Assess Improvement in Therapeutic Outcomes by Optimizing Platelet Inhibition with Prasugrel–Thrombolysis In Myocardial Infarction), prasugrel was associated with a significant 2.2% reduction in absolute risk and a 19% reduction in relative risk in the composite endpoint of cardiovascular death, nonfatal MI, or nonfatal stroke, and a significant increase in the rate of TIMI major hemorrhage (1.8% versus 2.4%) (567). Prasugrel is contraindicated in patients with a history of transient ischemic attack or stroke. Patients weighing <60 kg have an increased risk of bleeding on the 10 mg daily maintenance dose. The package insert suggests that consideration should be given to lowering the maintenance dose to 5 mg daily, although the effectiveness and safety of the 5-mg dose has not been studied. Prasugrel is not recommended for patients >75 years of age because of the increased risk of fatal and intracranial bleeding and lack of benefit, except in patients with diabetes or a history of prior MI. Prasugrel should not be started in patients likely to undergo urgent CABG. Prasugrel has not been studied in elective PCI, and thus no recommendation can be made regarding its use in this clinical setting.

Ticagrelor reversibly binds the $P2Y_{12}$ receptor. Unlike clopidogrel or prasugrel, ticagrelor is not a thienopyridine. It also does not require metabolic conversion to an active metabolite. Compared with clopidogrel in patients with ACS in the PLATO (Platelet Inhibition and Patient Outcomes) trial, ticagrelor was associated with a significant 1.9% reduction in absolute risk and a 16% reduction in relative risk in the primary composite endpoint of vascular death, nonfatal MI, or nonfatal stroke (568). Importantly, a

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significant reduction in vascular mortality and all-cause mortality was observed. Although CABG-related bleeding was not significantly increased with ticagrelor compared with clopidogrel, a significantly greater incidence of major bleeding was observed in patients not undergoing CABG. Ticagrelor was associated with higher rates of transient dyspnea and bradycardia compared with clopidogrel, although only a very small percentage of patients discontinued the study drug because of dyspnea. Based on post hoc analysis of the PLATO study, specifically the results in the U.S. patient cohort, a black box warning states that maintenance doses of aspirin above 100 mg reduce the effectiveness of ticagrelor and should be avoided. After any initial dose, ticagrelor should be used with aspirin 75 mg to 100 mg per day (583). Given the twice-daily dosing and reversible nature of the drug, patient compliance may be a particularly important issue to consider and emphasize. Ticagrelor has not been studied in elective PCI or in patients who received fibrinolytic therapy; thus, no recommendations about its use in these clinical settings can be made.

5.7.3. IV Antiplatelet Therapy: Recommendations

STEMI

CLASS IIa

1. In patients undergoing primary PCI treated with UFH, it is reasonable to administer a GP IIb/IIIa inhibitor (abciximab, double-bolus eptifibatide, or high-bolus dose tirofiban), whether or not patients were pretreated with clopidogrel (584–590). *(For GP IIb/IIIa inhibitor administration in patients not pretreated with clopidogrel, Level of Evidence: A; for GP IIb/IIIa inhibitor administration in patients pretreated with clopidogrel, Level of Evidence: C)*

CLASS IIb

1. In patients undergoing primary PCI with abciximab, it may be reasonable to administer intracoronary abciximab (589,591–604). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. Routine precatheterization laboratory (e.g., ambulance or emergency department) administration of GP IIb/IIIa inhibitors as part of an upstream strategy for patients with STEMI undergoing PCI is not beneficial (605–612). *(Level of Evidence: B)*

UA/NSTEMI

CLASS I

1. In UA/NSTEMI patients with high-risk features (e.g., elevated troponin level) not treated with bivalirudin and not adequately pretreated with clopidogrel, it is useful at the time of PCI to administer a GP IIb/IIIa inhibitor (abciximab, double-bolus eptifibatide, or high-bolus dose tirofiban) in patients treated with UFH (613–618). *(Level of Evidence: A)*

CLASS IIa

1. In UA/NSTEMI patients with high-risk features (e.g., elevated troponin level) treated with UFH and adequately pretreated with clopidogrel, it is reasonable at the time of PCI to administer a GP IIb/IIIa inhibitor (abciximab, double-bolus eptifibatide, or high-bolus dose tirofiban) (616,619). *(Level of Evidence: B)*

SIHD

CLASS IIa

1. In patients undergoing elective PCI treated with UFH and not pretreated with clopidogrel, it is reasonable to administer a GP IIb/IIIa inhibitor (abciximab, double-bolus eptifibatide, or high-bolus dose tirofiban) (619–621). *(Level of Evidence: B)*

CLASS IIb

1. In patients undergoing elective PCI with stent implantation treated with UFH and adequately pretreated with clopidogrel, it might be reasonable to administer a GP IIb/IIIa inhibitor (abciximab, double-bolus eptifibatide, or high-bolus dose tirofiban) (619,622–624). *(Level of Evidence: B)*

See Online Data Supplement 24 for additional data regarding IV antiplatelet therapy.

In the era before DAPT, trials of adequately dosed GP IIb/IIIa inhibitors in patients undergoing balloon angioplasty and coronary stent implantation demonstrated a reduction in the incidence of composite ischemic events with GP IIb/IIIa treatment, primarily through a reduction of enzymatically defined MI (613,615,618,620,621). Earlier RCTs of GP IIb/IIIa inhibitors were generally conducted in patients treated with UFH. In some trials, use of GP IIb/IIIa inhibitors are associated with some increased bleeding risk, and trials of these agents have generally excluded patients at high risk of bleeding (e.g., coagulopathy) (584,587–589,613–618,620–626). Thus, recommendations about use of GP IIb/IIIa inhibitors are best construed as applying to those patients not at high risk of bleeding complications. Abciximab, double-bolus eptifibatide (180 mcg/kg bolus followed 10 minutes later by a second 180 mcg/kg bolus), and high-bolus dose tirofiban (25 mcg/kg) all result in a high degree of platelet inhibition (627–629), have been demonstrated to reduce ischemic complications in patients undergoing PCI (608,609,613,615,618–621), and appear to lead to comparable angiographic and clinical outcomes (630,631).

Trials of GP IIb/IIIa inhibitors in the setting of STEMI and primary PCI were conducted in the era before routine stenting and DAPT. The results of these and more recent trials, as well as several meta-analyses, have yielded mixed results (584–590). Therefore, it is reasonable to administer GP IIb/IIIa inhibitors in patients with STEMI undergoing PCI, although these agents cannot be definitively recommended as routine therapy. These agents might provide more benefit in selective use, such as in patients with large anterior MI and/or large thrombus burden. Trials of precatheterization laboratory (e.g., ambulance or emergency room) administered GP IIb/IIIa inhibitors in patients with STEMI undergoing PCI, with or without fibrinolytic therapy, have generally shown no clinical benefit, and GP IIb/IIIa inhibitor use in this setting may be associated with an increased risk of bleeding (605–610,612). Studies of intracoronary GP IIb/IIIa inhibitor administration (predominantly using abciximab) consist of several small RCTs, retrospective analyses, retrospective and prospective regis-

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Table 12. Dosing of Parenteral Anticoagulants During PCI

Drug	Patient Has Received Prior Anticoagulant Therapy	Patient Has Not Received Prior Anticoagulant Therapy
UFH	• IV GPI planned: additional UFH as needed (e.g., 2,000 to 5,000 U) to achieve an ACT of 200 to 250 s • No IV GPI planned: additional UFH as needed (e.g., 2,000 to 5,000 U) to achieve an ACT of 250 to 300 s for HemoTec, 300 to 350 s for Hemochron	• IV GPI planned: 50 to 70 U/kg bolus to achieve an ACT of 200 to 250 s • No IV GPI planned: 70 to 100 U/kg bolus to achieve target ACT of 250 to 300 s for HemoTec, 300 to 350 s for Hemochron
Enoxaparin	• For prior treatment with enoxaparin, if the last SC dose was administered 8 to 12 h earlier or if only 1 SC dose of enoxaparin has been administered, an IV dose of 0.3 mg/kg of enoxaparin should be given. • If the last SC dose was administered within the prior 8 h, no additional enoxaparin should be given.	0.5 to 0.75 mg/kg IV bolus
Bivalirudin	For patients who have received UFH, wait 30 min, then give 0.75 mg/kg IV bolus, then 1.75 mg/kg per h IV infusion.	0.75 mg/kg bolus, 1.75 mg/kg per h IV infusion
Fondaparinux	For prior treatment with fondaparinux, administer additional IV treatment with an anticoagulant possessing anti-IIa activity, taking into account whether GPI receptor antagonists have been administered.	N/A
Argatroban	200 mcg/kg IV bolus, then 15 mcg/kg per min IV infusion	350 mcg/kg bolus, then 15 mcg/kg per min IV infusion

ACT indicates activated clotting time; IV, intravenous; GPI, glycoprotein inhibitor; N/A, not applicable; PCI, percutaneous coronary intervention; SC, subcutaneous; and UFH, unfractionated heparin.

tries, cohort analyses, and case reports. Although most of these published studies have reported some benefit of intracoronary administration in terms of acute angiographic parameters, infarct size, left ventricle myocardial salvage, and composite clinical endpoints, several other studies have not detected any benefit with intracoronary administration (589,591–604).

Trials of GP IIb/IIIa inhibitors in patients with UA/NSTEMI undergoing PCI demonstrated reduced ischemic outcomes, particularly in those with high-risk features such as positive biomarkers. Most trials were conducted in a prior PCI era and without $P2Y_{12}$ inhibitor pretreatment (613,615,618,632,633), although several trials have also demonstrated benefit in patients with high-risk features pretreated with clopidogrel (616,619). In most older studies of stable patients undergoing balloon angioplasty or coronary stenting, treatment with GP IIb/IIIa inhibitors resulted in a reduction of composite ischemic events, primarily enzymatically defined MI (613–618,620,621,634,635). More contemporary trials of patients pretreated with a thienopyridine have not demonstrated any benefit with GP IIb/IIIa inhibitor therapy in patients with stable symptoms undergoing elective PCI (619,622–624).

5.7.4. Anticoagulant Therapy

5.7.4.1. USE OF PARENTERAL ANTICOAGULANTS DURING PCI: RECOMMENDATION

CLASS I

1. An anticoagulant should be administered to patients undergoing PCI. *(Level of Evidence: C)*

Anticoagulant therapy prevents thrombus formation at the site of arterial injury, on the coronary guidewire, and in the catheters used for PCI (8). With rare exceptions (636), all PCI studies have used some form of anticoagulant. It is the consensus of the writing committee that PCI be performed with the use of some form of anticoagulant therapy. Suggested dosing regimens of parenteral agents used in PCI are given in Table 12. Recommendations for antiplatelet and antithrombin pharmacotherapy in PCI are given in Table 13.

5.7.4.2. UFH: RECOMMENDATION

CLASS I

1. Administration of IV UFH is useful in patients undergoing PCI. *(Level of Evidence: C)*

As the only anticoagulant available for PCI for many years, UFH became the standard of care by default (8). The dose of UFH for PCI has been based on empiricism and experience from RCTs. Suggested UFH dosing regimens are given in Table 12. When UFH is used during PCI, most cardiologists assess the degree of anticoagulation by measuring the activated clotting time. Although measurements are useful to show that an anti-IIa anticoagulant has been given, the value of the activated clotting time in current practice has been questioned. Although studies in the balloon angioplasty era did demonstrate a relationship between activated clotting time levels and ischemic complications (653–655), more recent analyses from the coronary stent era have not found a clear relationship between activated clotting time and outcomes (349,656,657). There may, however, be a modest relation between bleeding and activated clotting time levels (349,657). In addition, not only are there differences between activated clotting time levels measured by Hemochron and HemoTec devices, but both devices have less than optimal precision (658). Thus, although traditional target activated clotting time levels are included in this document, the utility of measured activated clotting time levels in current practice should be considered uncertain.

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Table 13. Recommendations for Antiplatelet and Antithrombin Pharmacotherapy at the Time of PCI

	COR	LOE	References	Relevant Caveats/Comments
Oral antiplatelet agents				
Aspirin	I	B	(301–304, 560–563)	N/A
$P2Y_{12}$ inhibitors	I	A	(564–568)	• A loading dose of a $P2Y_{12}$ inhibitor should be given to patients undergoing PCI with stenting.
• Clopidogrel	I	B	(564–566)	• 600-mg loading dose now recommended.
• Prasugrel	I	B	(567)	• Contraindicated in patients with prior TIA/CVA: ***Class III: Harm; LOE: B.*** • Generally not recommended in patients >75 y of age (Section 5.7.2). • Consideration of using a lower maintenance dose in patients weighing <60 kg suggested by FDA (Section 5.7.2).
• Ticagrelor	I	B	(568)	• Issues of patient compliance may be especially important.
GP IIb/IIIa inhibitors (abciximab, double-bolus eptifibatide, high-bolus dose tirofiban)				
• No clopidogrel pretreatment	STEMI: IIa	A	(584–590)	• UA/NSTEMI recommendation applies to those with high-risk features. • GPI use in STEMI may be most appropriate in those with large anterior MI and/or large thrombus burden. • IC abciximab administration in STEMI: ***Class IIb; LOE: B.*** • Precatheterization laboratory GPI administration in STEMI: ***Class III: No Benefit; LOE: B.*** • Recommendations apply to those not at high risk for bleeding complications.
	UA/NSTEMI: I	A	(613–618)	
	SIHD: IIa	B	(619–621)	
• Clopidogrel pretreatment	STEMI: IIa	C	(584–590)	
	UA/NSTEMI: IIa	B	(616, 619)	
	SIHD: IIb	B	(619, 622–624)	
Antithrombin agents				
UFH	I	C	N/A	• Dosing based on whether or not GPI was administered.
Bivalirudin	I	B	(625, 637–645)	• Lower bleeding rates associated with bivalirudin are mitigated when used concomitantly with a GPI.
Enoxaparin	IIb	B	(646–650)	• Recommendations apply to administration of IV enoxaparin at the time of PCI for those who have not received prior antithrombin therapy or who have received "upstream" SC enoxaparin therapy for UA/NSTEMI. • An additional dose of 0.3 mg/kg IV enoxaparin should be administered at the time of PCI to patients who have received <2 therapeutic SC doses (e.g., 1 mg/kg) or received the last SC enoxaparin dose 8 to 12 h before PCI: ***Class I; LOE: B.*** • Patients treated with SC enoxaparin within 12 h of PCI should not receive additional treatment with UFH during PCI ("stacking"): ***Class III: Harm; LOE: B.***
Anti-Xa inhibitors				
Fondaparinux	III: Harm	C	(651, 652)	• PCI should not be performed with fondaparinux as the sole antithrombin agent in patients treated with upstream fondaparinux. An additional anticoagulant with anti-IIa activity should be administered.

ACT indicates activated clotting time; COR, class of recommendation; CVA, cerebrovascular accident; FDA, U.S. Food and Drug Administration; GP, glycoprotein; GPI, glycoprotein IIb/IIIa inhibitor; IC, intracoronary; IV, intravenous; LOE, level of evidence; MI, myocardial infarction; N/A, not applicable; PCI, percutaneous coronary intervention; SC, subcutaneous; SIHD, stable ischemic heart disease; STEMI, ST-elevation myocardial infarction; TIA, transient ischemic attack; UA/NSTEMI, unstable angina/non–ST-elevation myocardial infarction; and UFH, unfractionated heparin.

Most cardiologists remove femoral sheaths when the activated clotting time falls to <150 to 180 seconds or when the activated partial thromboplastin time falls to <50 seconds. Full-dose anticoagulation is no longer used after successful PCI procedures. Almost all large clinical trials have enrolled patients who underwent transfemoral PCI, but recent small studies assessing the transradial approach have used similar doses of UFH (659) and similar activated clotting time target levels (660).

5.7.4.3. ENOXAPARIN: RECOMMENDATIONS

CLASS I

1. An additional dose of 0.3 mg/kg IV enoxaparin should be administered at the time of PCI to patients who have received fewer than 2 therapeutic subcutaneous doses (e.g., 1 mg/kg) or received the last subcutaneous enoxaparin dose 8 to 12 hours before PCI (649,661–664). *(Level of Evidence: B)*

CLASS IIb

1. Performance of PCI with enoxaparin may be reasonable in patients either treated with "upstream" subcutaneous enoxaparin for UA/NSTEMI or who have not received prior antithrombin therapy and are administered IV enoxaparin at the time of PCI (646–650). (*Level of Evidence: B*)

CLASS III: HARM

1. UFH should not be given to patients already receiving therapeutic subcutaneous enoxaparin (649,665). *(Level of Evidence: B)*

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Trials of enoxaparin relevant to PCI include both studies in which patients with UA/NSTEMI were started on upstream subcutaneous enoxaparin therapy that was continued up to the time of PCI and trials in which patients who had received no prior antithrombin therapy were treated with IV enoxaparin at the time of PCI (646–650,661–663,666). In the SYNERGY (Superior Yield of the New strategy of Enoxaparin, Revascularization and Glycoprotein IIb/IIIa Inhibitors) trial, there was an increased incidence of bleeding in those treated with upstream enoxaparin, later attributed at least in part to the fact that some patients being treated with enoxaparin were also administered UFH at the time of PCI (so-called "stacking") (649,665). Almost all patients undergoing elective PCI who are administered enoxaparin (0.5 mg/kg IV) will have a peak anti-Xa level >0.5 IU/mL (647). Most clinical studies have used a regimen of 0.5 to 0.75 mg IV (667). Several studies have used this regimen in elective patients and those with STEMI (646). Patients who have received multiple doses of subcutaneously administered enoxaparin who undergo PCI within 8 hours of the last subcutaneous dose generally have adequate degrees of anticoagulation to undergo PCI, but the degree of anticoagulation may diminish in the 8- to 12-hour period after the last subcutaneous dose. In such patients, as well as in patients who have received only 1 subcutaneous dose of enoxaparin, the addition of enoxaparin (0.3 mg/kg IV) at the time of PCI provides an additional degree of anticoagulation and has become standard practice (648,661–664). Patients who undergo PCI >12 hours after the last subcutaneous dose are usually treated with full-dose de novo anticoagulation using an established regimen (e.g., full-dose UFH or bivalirudin).

5.7.4.4. BIVALIRUDIN AND ARGATROBAN: RECOMMENDATIONS

CLASS I

1. For patients undergoing PCI, bivalirudin is useful as an anticoagulant with or without prior treatment with UFH (625,637–645). *(Level of Evidence: B)*
2. For patients with heparin-induced thrombocytopenia, it is recommended that bivalirudin or argatroban be used to replace UFH (668,669). *(Level of Evidence: B)*

Bivalirudin is being increasingly used in clinical practice (670) as evidence emerges from clinical trials across the spectrum of CAD (638–644). In individual trials and meta-analyses, the use of bivalirudin has been associated with reduced bleeding compared with UFH plus a GP IIb/IIIa inhibitor, although concerns about ischemic events have emerged in individual studies (625,637–645). Longer-term follow-up of the major bivalirudin trials, however, suggests that small or nominal increases in ischemic events have not translated into long-term consequences and that treatment at or before the time of PCI with clopidogrel may mitigate any increased early ischemic risk (637–645). Thus, a treatment strategy of bivalirudin compared with heparin (or enoxaparin) plus GP IIb/IIIa inhibitor appears to lower the risk of bleeding complications. The lower bleeding rates associated with bivalirudin (compared with UFH plus a GP IIb/IIIa inhibitor) are mitigated when used concomitantly with a GP IIb/IIIa inhibitor (639). A strategy of use of provisional GP IIb/IIIa inhibitor in patients treated with bivalirudin is widely accepted (639,643,644).

In patients with heparin-induced thrombocytopenia (671,672), a direct-thrombin inhibitor (argatroban) has been approved as an alternative parenteral anticoagulant to be used during PCI (668). The use of bivalirudin for heparin-induced thrombocytopenia has been reported as well (669).

5.7.4.5. FONDAPARINUX: RECOMMENDATION

CLASS III: HARM

1. Fondaparinux should not be used as the sole anticoagulant to support PCI. An additional anticoagulant with anti-IIa activity should be administered because of the risk of catheter thrombosis (651,652). *(Level of Evidence: C)*

Fondaparinux, a pentasaccharide, is an indirect factor Xa inhibitor but has no effect on thrombin. On the basis of reports of catheter thrombosis when fondaparinux is used alone during primary PCI (651,652), the writing committee recommends that an anticoagulant with anti-IIa activity be used in patients undergoing PCI (651,652). One study suggested that clinical outcomes were better when fondaparinux was replaced during PCI by a standard dose of UFH (85 U/kg, 60 U/kg with GP IIb/IIIa inhibitors) rather than by a low dose (50 U/kg) (673).

5.7.5. No-Reflow Pharmacological Therapies: Recommendation

CLASS IIa

1. Administration of an intracoronary vasodilator (adenosine, calcium channel blocker, or nitroprusside) is reasonable to treat PCI-related no-reflow that occurs during primary or elective PCI (674–689). *(Level of Evidence: B)*

See Online Data Supplement 25 for additional data regarding no-reflow therapies.

No-reflow is a broad term used to describe 2 distinct entities. The first is "interventional no-reflow" attributed to vasospasm and downstream embolization of debris dislodged during PCI, usually in the setting of atherectomy, thrombus, or degenerated SVGs. The second entity is suboptimal reperfusion of an infarct artery, attributed to endothelial injury in addition to embolization and vasospasm. Angiographic no-reflow is the most obvious sequela of the same pathophysiology that produces abnormal TIMI frame counts and TIMI blush scores, so these measures are often used interchangeably. The principal clinical sequela of no-reflow is myonecrosis. Efforts to prevent no-reflow overlap with strategies to reduce MI size and prevent periprocedural MI.

In the setting of MI, several drugs have been shown to reduce the incidence of no-reflow. Evidence for a beneficial effect on no-reflow exists for abciximab, adenosine, nic-

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orandil, and nitroprusside (674,675,680,682,683,685,687,688,690). However, their adoption into clinical practice has depended on their effect on hard clinical endpoints such as infarct size and mortality. These benefits, and consequentially the use of these agents, have been limited.

For interventional no-reflow, several therapies have proven effective after no-reflow has started. These include adenosine, calcium channel blockers, and nitroprusside (676,678,679,681,684,686,689,691). There are fewer data to support the use of epinephrine (692). No-reflow after rotational atherectomy was less common with nicorandil compared with verapamil infusions in 3 studies (693–695), and an infusion of nicorandil/adenosine during rotational atherectomy prevented no-reflow in 98% of patients (677). Trials of pre-PCI intracoronary verapamil, nicardipine, and adenosine have reported them to be safe but have not demonstrated reductions in post-PCI no-reflow (696–698). Mechanical devices to prevent interventional and myocardial infarct reperfusion no-reflow are also covered in Section 5.5.5.

5.8. PCI in Specific Anatomic Situations

5.8.1. CTOs: Recommendation

CLASS IIa

1. PCI of a CTO in patients with appropriate clinical indications and suitable anatomy is reasonable when performed by operators with appropriate expertise (699–703). *(Level of Evidence: B)*

See Online Data Supplements 26 to 28 for additional data regarding CTOs.

Approximately one third of patients with suspected CAD who undergo coronary angiography have ≥1 CTO (defined as occlusion of a duration >3 months) (704). Although stress-induced ischemia can be elicited in the majority of patients with CTO despite the presence of collaterals (706,707), only 8% to 15% of these patients undergo PCI (708,709). The disparity between the frequency of CTOs and percutaneous treatment underscores not only the technical and procedural complexities of this lesion subtype but also the clinical uncertainties regarding which patients benefit from CTO revascularization. Studies suggest that patients who undergo successful, rather than failed, recanalization of CTOs fare better in terms of symptom status and need for CABG (699), as well as LV function (710). However, the impact of successful CTO recanalization on long-term survival remains unsettled (701,711,712). The decision to try PCI for a CTO (versus continued medical therapy or surgical revascularization) requires an individualized risk-benefit analysis encompassing clinical, angiographic, and technical considerations. Consultation with a cardiothoracic surgeon and use of the Heart Team approach in cases of CTO in which a large territory is subtended and/or multivessel CAD is present are frequently done.

From a technical perspective, successful recanalization of CTOs has steadily increased over the years because of adoption of dedicated wires, novel techniques, and increased operator experience (702). In patients who undergo successful CTO recanalization, use of DES significantly reduces the need for repeated target-vessel revascularization, compared with BMS and balloon angioplasty, without compromising safety (703,713–719).

5.8.2. SVGs: Recommendations

CLASS I

1. EPDs should be used during SVG PCI when technically feasible (532–535). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. Platelet GP IIb/IIIa inhibitors are not beneficial as adjunctive therapy during SVG PCI (212,571,720,721). *(Level of Evidence: B)*

CLASS III: HARM

1. PCI is not recommended for chronic SVG occlusions (722–724). *(Level of Evidence: C)*

See Online Data Supplement 29 for additional data regarding SVG.

Adverse cardiac event rates are doubled after SVG PCI compared with native-artery PCI (536). A distal balloon occlusion EPD decreased the 30-day composite outcome of death, MI, emergency CABG, or target-lesion revascularization (9.6% versus 16.5%) in the only RCT comparing embolic protection with no embolic protection (532). Subsequent noninferiority comparisons have demonstrated similar benefit with proximal occlusion and distal filter EPDs, with benefit limited to reduction in periprocedural MI (534,535). PCI in chronic SVG occlusion is associated with low success rates, high complication rates, and poor long-term patency rates (722,723). Restenosis and target-vessel revascularization rates are lower with DES compared with BMS, although mortality and stent thrombosis rates are similar (725). The use of covered stents is limited to the treatment of the uncommon complication of SVG perforation. Balloon angioplasty for distal SVG anastomotic stenoses has low restenosis rates (724), so stenting is commonly reserved at this location for suboptimal balloon angioplasty results or restenosis. Routine GP IIb/IIIa inhibitor therapy has not proven beneficial in SVG PCI (720). Fibrinolytic therapy is no longer used for thrombus-containing lesions, but rheolytic or manual aspiration thrombectomy is sometimes employed.

5.8.3. Bifurcation Lesions: Recommendations

CLASS I

1. Provisional side-branch stenting should be the initial approach in patients with bifurcation lesions when the side branch is not large and has only mild or moderate focal disease at the ostium (726–729). *(Level of Evidence: A)*

CLASS IIa

1. It is reasonable to use elective double stenting in patients with complex bifurcation morphology involving a large side branch where the risk of side-branch occlusion is high and the likelihood of

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successful side-branch reaccess is low (730–733). *(Level of Evidence: B)*

Side-branch occlusion or severe stenosis after stenting the main artery in coronary bifurcation PCI occurs in 8% to 80% of unselected patients (732,734). The frequency of side-branch occlusion is related to complex bifurcation morphology (severe and/or long side-branch ostial stenosis, large plaque burden in the side-branch ostium, and/or unfavorable side-branch angulation) (732,735,736). Side-branch occlusion after PCI is associated with Q-wave and non–Q-wave MI (734,735). Therefore, preservation of physiologic flow in the side branch after PCI is important (736). There are 2 bifurcation PCI strategies: provisional stenting (stenting the main vessel with additional balloon angioplasty or stenting of the side branch only in the case of an unsatisfactory result) and elective double stenting of the main vessel and the side branch. When there is an unsatisfactory result in the side branch from the provisional stent in the main branch, sometimes balloon angioplasty alone in the side branch will improve the result and stenting the side branch is not necessary. Some experts have suggested that using the side-branch balloon alone will distort the main branch stent and thus this always needs to be a kissing balloon inflation.

In patients with low-risk bifurcation lesions (minimal or moderate ostial side-branch disease [<50% diameter stenosis] of focal length [5 to 6 mm]), provisional stenting yields similar clinical outcome to elective double stenting, with lower incidence of periprocedural biomarker elevation (726–729). Conversely, in patients with high-risk bifurcations, elective double stenting is associated with a trend toward higher angiographic success rates, lower in-hospital MACE, and better long-term patency of the side branch compared with provisional stenting (193). Culotte, Crush, and T-stent techniques have been studied in RCTs (726–729,737). Use of DES yields better outcomes than BMS (738), and sirolimus-eluting stents yield better outcomes than paclitaxel-eluting stents (739–742). Clinical evidence supports the use of final kissing balloon inflation after elective double stenting (743).

5.8.4. Aorto-Ostial Stenoses: Recommendations

CLASS IIa

1. IVUS is reasonable for the assessment of angiographically indeterminant left main CAD (744,745). *(Level of Evidence: B)*
2. Use of DES is reasonable when PCI is indicated in patients with an aorto-ostial stenosis (746,747). *(Level of Evidence: B)*

Aorto-ostial stenoses of native coronary arteries (left main coronary artery and right coronary artery) are most commonly caused by atherosclerosis, but they can also occur in patients with congenital malformations, radiation exposure, vasculitides, and aortic valve replacement. The angiographic diagnosis of aorto-ostial disease is not always straightforward, especially in the ostial left main coronary artery, where eccentricity and angulation can be mistaken for stenosis (490,748). Aorto-ostial disease can be evaluated with IVUS (744,745); FFR (with IV adenosine) has also been used (484,749). The treatment of aorto-ostial stenoses with balloon angioplasty has been associated with lower procedural success rates, more frequent in-hospital complications, and a greater likelihood of late restenosis (750). Although atherectomy devices (directional atherectomy, rotational atherectomy, and excimer laser angioplasty) have improved acute angiographic results over balloon angioplasty, restenosis has remained a limitation (751). In patients with aorto-ostial stenoses undergoing PCI, use of DES has been shown to reduce restenosis compared with BMS (176,746,752).

5.8.5. Calcified Lesions: Recommendation

CLASS IIa

1. Rotational atherectomy is reasonable for fibrotic or heavily calcified lesions that might not be crossed by a balloon catheter or adequately dilated before stent implantation (514,515,520). *(Level of Evidence: C)*

The presence of coronary calcification is a marker for significant CAD and increased long-term mortality (753). Calcified coronary lesions are not a homogenous entity, and their response to PCI varies according to severity of calcification. Severely calcified lesions respond poorly to balloon angioplasty (230,754), and when stents are implanted in such lesions, an incomplete and asymmetrical stent expansion occurs in the majority of cases (755). Attempts to remedy the underexpanded stents with aggressive high-pressure balloon dilatation may result in coronary artery rupture (756). All the published prospective RCTs that evaluated the various catheter-based coronary interventional devices excluded patients with severely calcified lesions. Therefore, the evidence base for best PCI practices in patients with severely calcified lesions comes from nonrandomized single-arm studies. Among the various adjunct devices that are used to facilitate PCI in severely calcified lesions, only rotational atherectomy has been shown to have potential utility (514,757). Although rotational atherectomy increases the chances of angiographic success in severely calcified lesions, its use as a stand-alone device has not led to a reduction in restenosis (520,521,758). Several retrospective studies have shown that in patients with severely calcified lesions, the use of rotational atherectomy before implantation of BMS (514) or DES (515) is safe. Intermediate-term patency is more favorable with DES than BMS (759).

5.9. PCI in Specific Patient Populations

Several specific patient subsets with higher risks for PCI, and at times higher absolute clinical benefit, have traditionally been underrepresented in RCTs and are described below.

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5.9.1. Elderly

The elderly constitute a growing proportion of patients considered for PCI (760). In 1 series examining trends over a 25-year period, the proportion of patients undergoing PCI who were 75 to 84 years of age doubled, and those >85 years of age increased 5-fold (761). Age is one of the strongest predictors of mortality after PCI (762), and elderly patients present with a substantially higher clinical risk profile (760). Nonetheless, the angiographic success rates and clinical benefits of PCI in elderly patients are similar to younger patients (763). In fact, the absolute benefit is typically greater because of higher absolute risk of adverse outcomes in these patients (764). However, increased risks of complications such as major bleeding and stroke mandate careful consideration of the benefits and risks of PCI in elderly patients (373).

5.9.2. Diabetes

Patients with diabetes represent approximately one third of patients undergoing PCI in the United States. Restenosis, which had been a major limitation of PCI, is significantly reduced in patients with diabetes treated with DES compared with BMS (471). However, there are no definitive data from RCTs supporting different clinical outcomes for different types of DES (765), with a recent meta-analysis of 35 RCTs involving 3,852 patients with diabetes unable to find major differences between patients receiving sirolimus-eluting stents or paclitaxel-eluting stents (472). Numerous analyses and clinical studies have evaluated how the presence of diabetes may impact the clinical outcome of patients undergoing PCI and decisions about PCI or CABG (14,116,163,164,186). These studies and the approach to revascularization decisions in diabetes are addressed in Section 4.

Diabetes is an important risk factor for the development of contrast-induced AKI. Strategies to reduce the risk of contrast-induced AKI in patients with diabetes are discussed in Section 4.4.

5.9.3. Women

Cardiovascular disease is the leading cause of death in women in the United States and Europe (766), and an estimated 35% of PCIs in the United States are performed in women (767,768). Women undergoing PCI usually have more risk factors (including hypertension, advanced age, elevated cholesterol, and more significant and diffuse CAD) compared with men (769). Women with STEMI are also less likely to receive early medical treatments and experience longer delays to reperfusion therapy (770,771). In subgroup analyses of clinical trials, use of DES appears to be similarly efficacious in women and men (772).

5.9.4. CKD: Recommendation

CLASS I

1. In patients undergoing PCI, the glomerular filtration rate should be estimated and the dosage of renally cleared medications should be adjusted (298–300). *(Level of Evidence: B)*

CKD is an independent risk factor for the development and progression of CAD (773,774), and is also associated with worse prognosis after MI or PCI (369,775). A glomerular filtration rate of <60 mL/min per 1.73 m^2 of body surface area should be considered abnormal. Patients with CKD undergoing PCI have a higher risk of complications, including bleeding (776), AKI, and death (236,777), but CKD is not a strong predictor of restenosis after BMS or DES (778). Strategies to reduce the risk of contrast-induced AKI in patients with CKD are discussed in Section 4.4. Platelet dysfunction and overdosing of antiplatelet and antithrombin drugs (350) in patients with CKD contribute to the increased risk of bleeding. The Cockcroft-Gault formula is commonly used as a surrogate marker for estimating creatinine clearance, which in turn estimates glomerular filtration rate (298,299,779,780). Medications that require dosage adjustments in patients with CKD include eptifibatide, tirofiban, bivalirudin, enoxaparin, and fondaparinux (781).

5.9.5. Cardiac Allografts

Cardiac allograft vasculopathy is a major cause of death in cardiac transplant recipients after their first year of survival (782). In general, revascularization for cardiac allograft vasculopathy with PCI is only palliative, with no evidence supporting benefit in regard to long-term survival or avoidance of retransplantation. The restenosis rate after PCI in patients with cardiac allograft vasculopathy is high, although stent implantation reduces early and midterm restenosis compared with balloon angioplasty. DES have been shown to have a tendency to lower restenosis rates compared with BMS (783,784). Thus, many clinicians perform stenting with DES or BMS in cardiac transplant patients with discrete lesions who have an abnormal stress test or symptoms suggestive of myocardial ischemia.

5.10. Periprocedural MI Assessment: Recommendations

CLASS I

1. In patients who have signs or symptoms suggestive of MI during or after PCI or in asymptomatic patients with significant *persistent* angiographic complications (e.g., large side-branch occlusion, flow-limiting dissection, no-reflow phenomenon, or coronary thrombosis), creatinine kinase-MB and troponin I or T should be measured. *(Level of Evidence: C)*

CLASS IIb

1. Routine measurement of cardiac biomarkers (creatinine kinase-MB and/or troponin I or T) in all patients after PCI may be reasonable. *(Level of Evidence: C)*

Major events leading to ischemia or MI after PCI include acute closure, embolization and no-reflow, side-branch occlusion, and acute stent thrombosis. Issues surrounding

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the routine assessment of cardiac biomarkers after PCI are complex, especially given that the definition of PCI-related MI has evolved over the years and most events are asymptomatic. The most recent consensus definition of MI considers troponin elevations of 3 times the upper limit of normal as a PCI-related MI in patients with normal baseline levels; this is further classified as a type 4a MI (240). This definition is supported by studies with delayed-enhancement MRI confirming that there is irreversible injury in the myocardium associated with biomarker elevations and that the size of this injury correlates with the degree of elevation (785). Furthermore, a meta-analysis of 15 observational studies found that troponin elevations at any level were linked with worse in-hospital and long-term outcomes; elevations >3 times the upper limit of normal predicted even worse outcomes (242). Other observational data, however, have raised concerns about whether the relationship is causal (786,787). A recent study found creatinine kinase-MB to correlate better with MRI-detected MI than troponin level (788). Definitions of PCI-related MI are being reevaluated by the Task Force for the Redefinition of Myocardial Infarction. Although there may be value for individual operators and hospitals to routinely measure cardiac biomarkers to track rates of PCI-related MI, at present there are not compelling data to recommend this for all PCI procedures.

5.11. Vascular Closure Devices: Recommendations

CLASS I

1. Patients considered for vascular closure devices should undergo a femoral angiogram to ensure their anatomic suitability for deployment. *(Level of Evidence: C)*

CLASS IIa

1. The use of vascular closure devices is reasonable for the purposes of achieving faster hemostasis and earlier ambulation compared with the use of manual compression (257,789–791). *(Level of Evidence: B)*

CLASS III: NO BENEFIT

1. The routine use of vascular closure devices is not recommended for the purpose of decreasing vascular complications, including bleeding (256,257,789–792). *(Level of Evidence: B)*

See Online Data Supplement 30 for additional data regarding vascular closure devices.

Vascular (arteriotomy) closure devices have been extensively reviewed (790), most recently in a 2010 AHA scientific statement (257), which issued several formal recommendations. The results of 4 meta-analyses have found that vascular closure devices decrease time to hemostasis compared with manual compression but do not decrease vascular complications, bleeding complications, or the need for blood transfusions (256,789,791,793). Future studies of vascular closure devices need to be randomized, include "high-risk" patients and "high-risk" anatomy, use blinded endpoint adjudication as much as possible, use well-defined and comprehensive complication endpoints, and be adequately powered to detect clinically important endpoints, particularly bleeding and vascular complications.

6. Postprocedural Considerations

Postprocedural considerations in patients undergoing PCI are discussed below and summarized in Table 14. Some recommendations and text regarding DAPT in Section 5.7.2 are intentionally repeated in this section for reader ease of use.

6.1. Postprocedural Antiplatelet Therapy: Recommendations

CLASS I

1. After PCI, use of aspirin should be continued indefinitely (560–563). *(Level of Evidence: A)*
2. The duration of $P2Y_{12}$ inhibitor therapy after stent implantation should generally be as follows:
   a. In patients receiving a stent (BMS or DES) during PCI for ACS, $P2Y_{12}$ inhibitor therapy should be given for at least 12 months. Options include clopidogrel 75 mg daily (570), prasugrel 10 mg daily (567), and ticagrelor 90 mg twice daily (568). *(Level of Evidence: B)*
   b. In patients receiving DES for a non-ACS indication, clopidogrel 75 mg daily should be given for at least 12 months if the patient is not at high risk of bleeding (208,212,571). *(Level of Evidence: B)*
   c. In patients receiving BMS for a non-ACS indication, clopidogrel should be given for a minimum of 1 month and ideally up to 12 months (unless the patient is at increased risk of bleeding; then it should be given for a minimum of 2 weeks) (572). *(Level of Evidence: B)*
3. Patients should be counseled on the importance of compliance with DAPT and that therapy should not be discontinued before discussion with their cardiologist (208). *(Level of Evidence: C)*

CLASS IIa

1. After PCI, it is reasonable to use aspirin 81 mg per day in preference to higher maintenance doses (302,573–576). *(Level of Evidence: B)*
2. If the risk of morbidity from bleeding outweighs the anticipated benefit afforded by a recommended duration of $P2Y_{12}$ inhibitor therapy after stent implantation, earlier discontinuation (e.g., <12 months) of $P2Y_{12}$ inhibitor therapy is reasonable. *(Level of Evidence: C)*

CLASS IIb

1. Continuation of clopidogrel, prasugrel, or ticagrelor beyond 12 months may be considered in patients undergoing placement of DES (567,568). *(Level of Evidence: C)*

Continued treatment with the combination of aspirin and a $P2Y_{12}$ inhibitor antagonist after PCI appears to reduce MACE (570,572). On the basis of RCT protocols, secondary prevention measures, and expert consensus opinion, aspirin 81 mg daily should be given indefinitely after PCI.

Likewise, $P2Y_{12}$ inhibitors should be given for a minimum of 1 month after BMS (minimum 2 weeks for patients at significant increased risk of bleeding) (580) and for 12 months after DES and ideally in all patients who are not at high risk of bleeding.

The 2009 STEMI/PCI guidelines update (10) listed the recommendation "if the risk of morbidity because of bleed-

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Table 14. Postprocedural Recommendations for Patients Undergoing PCI

Recommendations		COR	LOE	References
Aspirin				
After PCI, use of aspirin should be continued indefinitely.		I	A	(560–563)
After PCI, it is reasonable to use aspirin 81 mg/d in preference to higher maintenance doses.		IIa	B	(302,573–576)
$P2Y_{12}$ inhibitors				
In patients receiving a stent (BMS or DES) during PCI for ACS, $P2Y_{12}$ inhibitor therapy should be given for at least 12 mo. Options include clopidogrel 75 mg/d, prasugrel 10 mg/d, and ticagrelor 90 mg twice daily.		I	B	(567,568,570)
In patients receiving DES for a non-ACS indication, clopidogrel 75 mg/d should be given for at least 12 mo if patients are not at high risk of bleeding.		I	B	(208,212,571)
In patients receiving BMS for a non-ACS indication, clopidogrel should be given for a minimum of 1 mo and ideally up to 12 mo (unless the patient is at increased risk of bleeding; then it should be given for a minimum of 2 wk).		I	B	(572)
Patients should be counseled on the importance of compliance with DAPT and that therapy should not be discontinued before discussion with their cardiologist.		I	C	(208)
PPIs should be used in patients with a history of prior GI bleeding who require DAPT.		I	C	(794)
If the risk of morbidity from bleeding outweighs the anticipated benefit afforded by a recommended duration of $P2Y_{12}$ inhibitor therapy after stent implantation, earlier discontinuation (e.g., <12 mo) of $P2Y_{12}$ inhibitor therapy is reasonable.		IIa	C	N/A
Use of PPIs is reasonable in patients with an increased risk of GI bleeding (e.g., advanced age, concomitant use of warfarin, steroids, NSAIDs, *Helicobacter pylori* infection) who require DAPT.		IIa	C	(794)
Continuation of clopidogrel, prasugrel, or ticagrelor beyond 12 mo may be considered in patients undergoing placement of DES.		IIb	C	N/A
Routine use of a PPI is not recommended for patients at low risk of GI bleeding, who have much less potential to benefit from prophylactic therapy.		III: No Benefit	C	(794)
Exercise testing				
For patients entering a formal cardiac rehabilitation program after PCI, treadmill exercise testing is reasonable.		IIa	C	(567,568)
Routine periodic stress testing of asymptomatic patients after PCI without specific clinical indications should not be performed.		III: No Benefit	C	(795)
Cardiac rehabilitation				
Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for patients at moderate to high risk, for whom supervised exercise training is warranted.		I	A	(796–804)
Secondary prevention (recommendations included from the 2011 AHA/ACCF Secondary Prevention and Risk Reduction Therapy Guideline) (805)				
Lipid management with lifestyle modification and lipid-lowering pharmacotherapy	Lifestyle modification	I	B	(806,807)
	Statin therapy	I	A	(344,806,808–810,810a)
	Statin therapy which lowers LDL cholesterol to <100 mg/dL and achieves at least a 30% lowering of LDL cholesterol	I	C	(344,806,808–810,810a)
	Statin therapy which lowers LDL cholesterol to <70 mg/dL in very high-risk* patients	IIa	B	(345,808–810,810a,811,812)
Blood pressure control (with a blood pressure goal of <140/90 mm Hg)	Lifestyle modification	I	B	(813–817)
	Pharmacotherapy	I	A	(813,818,819)
Diabetes management (e.g., lifestyle modification and pharmacotherapy) coordinated with the patient's primary care physician and/or endocrinologist		I	C	N/A
Complete smoking cessation		I	A	(820–823)

*Presence of established cardiovascular disease plus 1) multiple major risk factors (especially diabetes), 2) severe and poorly controlled risk factors (especially continued cigarette smoking), 3) multiple risk factors of the metabolic syndrome (especially high triglycerides ≥200 mg/dL plus non–HDL cholesterol ≥130 mg/dL with low HDL cholesterol [<40 mg/dL]), and 4) acute coronary syndromes.

ACS indicates acute coronary syndromes; BMS, bare-metal stent(s); COR, class of recommendation; DAPT, dual antiplatelet therapy; DES, drug-eluting stent(s); GI, gastrointestinal; HDL, high-density lipoprotein; LDL, low-density lipoprotein; LOE, level of evidence; N/A, not applicable; NSAID, nonsteroidal anti-inflammatory drug; PCI, percutaneous coronary intervention; and PPI, proton pump inhibitor.

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ing outweighs the anticipated benefit afforded by thienopyridine therapy, earlier discontinuation *should be considered*" as a Class I recommendation, although the language used, in part, was consistent with a Class IIa recommendation. To clarify the intent of the recommendation, as well as to acknowledge the inherent difficulties in weighing bleeding and stent thrombosis risks, the recommendation is designated a Class IIa recommendation, using the phrase "earlier discontinuation *is reasonable*." Recommendations regarding $P2Y_{12}$ inhibitor discontinuation before elective or urgent CABG are provided in the "2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery" (824).

6.1.1. PPIs and Antiplatelet Therapy: Recommendations

CLASS I

1. PPIs should be used in patients with a history of prior gastrointestinal (GI) bleeding who require DAPT (794). *(Level of Evidence: C)*

CLASS IIa

1. Use of PPIs is reasonable in patients with an increased risk of GI bleeding (e.g., advanced age, concomitant use of warfarin, steroids, nonsteroidal anti-inflammatory drugs, *Helicobacter pylori* infection) who require DAPT (794). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. Routine use of a PPI is not recommended for patients at low risk of GI bleeding, who have much less potential to benefit from prophylactic therapy (794). *(Level of Evidence: C)*

See Online Data Supplement 31 for additional data regarding the clopidogrel–PPI interaction.

PPIs are often prescribed prophylactically when clopidogrel is started to prevent GI complications such as ulceration and bleeding due to DAPT (825). There is pharmacodynamic evidence that omeprazole interferes with clopidogrel metabolism (826,827), but there is no clear evidence implicating other PPIs. However, even with omeprazole, there are no convincing data supporting an important clinical drug–drug interaction (826). The FDA communication about an ongoing safety review of clopidogrel advises that healthcare providers avoid the use of clopidogrel in patients with impaired *CYP2C19* function due to known genetic variation or drugs that inhibit *CYP2C19* activity. The FDA notes that there is no evidence that other drugs that reduce stomach acid, such as histamine-2 receptor antagonists (except cimetidine) or antacids, interfere with clopidogrel responsiveness. The COGENT (Clopidogrel and the Optimization of Gastrointestinal Events) trial randomized patients with DAPT to clopidogrel and omeprazole or clopidogrel and placebo, and while there was no difference in cardiovascular events between the 2 groups, GI events were halved in those randomized to omeprazole (828). It is reasonable to carefully evaluate the indication for PPI therapy in patients treated with clopidogrel, based on the presence or absence of the risk factors discussed above (794). The need for GI protection increases with the number of risk factors for bleeding. Prior upper GI bleeding is the strongest and most consistent risk factor for GI bleeding on antiplatelet therapy. Patients with ACS and prior upper GI bleeding are at substantial cardiovascular risk, so DAPT with concomitant use of a PPI may provide the optimal balance of risk and benefit. It should be noted that PPIs, by decreasing adverse GI effects related to clopidogrel, might decrease patients' discontinuation of clopidogrel. In patients in whom there is a clear indication for PPI therapy, some clinicians may choose to use a PPI other than omeprazole.

6.1.2. Clopidogrel Genetic Testing: Recommendations

CLASS IIb

1. Genetic testing might be considered to identify whether a patient at high risk for poor clinical outcomes is predisposed to inadequate platelet inhibition with clopidogrel (829). *(Level of Evidence: C)*
2. When a patient predisposed to inadequate platelet inhibition with clopidogrel is identified by genetic testing, treatment with an alternate $P2Y_{12}$ inhibitor (e.g., prasugrel or ticagrelor) might be considered (829). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. The routine clinical use of genetic testing to screen patients treated with clopidogrel who are undergoing PCI is not recommended (829). *(Level of Evidence: C)*

On March 12, 2010, the FDA approved a new label for clopidogrel with a "boxed warning" about the diminished effectiveness of clopidogrel in patients with impaired ability to convert the drug into its active metabolite (829). Patients with decreased *CYP2C19* function because of genetic polymorphisms metabolize clopidogrel poorly and have higher rates of cardiovascular events after ACS and PCI than patients with normal *CYP2C19* function. The warning also notes that tests are available to identify patients with genetic polymorphisms and that alternative treatment strategies should be considered for patients who are poor metabolizers. The clopidogrel boxed warning leaves the issue of whether to perform *CYP2C19* testing up to the individual physician. It does not specifically require genetic testing or other changes in evaluation or treatment and does not imply that there are solid evidence-based reasons for such actions. Rather, it serves to inform clinicians of genetic variations in response to clopidogrel and to emphasize that clinicians should use this knowledge to make decisions about how to treat individual patients. At the present time, the evidence base is insufficient to recommend routine genetic testing in patients undergoing PCI. There may be a potential role for genetic testing for patients undergoing elective high-risk PCI procedures (e.g., unprotected left main, bifurcating left main, or last patent coronary artery).

6.1.3. Platelet Function Testing: Recommendations

CLASS IIb

1. Platelet function testing may be considered in patients at high risk for poor clinical outcomes (829). *(Level of Evidence: C)*

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2. In patients treated with clopidogrel with high platelet reactivity, alternative agents, such as prasugrel or ticagrelor, might be considered (829). *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. The routine clinical use of platelet function testing to screen patients treated with clopidogrel who are undergoing PCI is not recommended (829). *(Level of Evidence: C)*

Platelet function testing to tailor antiplatelet therapy has received considerable interest. The GRAVITAS (Gauging Responsiveness With A VerifyNow Assay-Impact On Thrombosis And Safety) trial and several other ongoing trials test the concept that tailoring antiplatelet therapy based on platelet responsiveness assessed in an ex vivo $P2Y_{12}$ assay will improve cardiovascular outcomes (830). In GRAVITAS, treatment with high-dose clopidogrel for 6 months in patients with high platelet reactivity on standard-dose clopidogrel was not beneficial. At the present time, the evidence base is insufficient to recommend routine platelet function testing. The results of 2 ongoing trials (DANTE [Dual Antiplatelet Therapy Tailored on the Extent of Platelet Inhibition] and ARCTIC [Double Randomization of a Monitoring Adjusted Antiplatelet Treatment Versus a Common Antiplatelet Treatment for DES Implantation, and Interruption Versus Continuation of Double Antiplatelet Therapy, One Year After Stenting]) will provide further information on the issue (www.clinicaltrials.gov).

6.2. Stent Thrombosis

The majority of stent thrombosis occurs early (0 to 30 days after PCI). In broad clinical practice, the expected rate of early stent thrombosis is <1%, and beyond 30 days it is 0.2% to 0.6% per year (210,831). Acute stent thrombosis often presents as STEMI, and emergency revascularization is indicated. Acute stent thrombosis is associated with mortality rates of 20% to 45% (832). Survivors are also at risk of recurrent stent thrombosis (833).

Mechanical and pharmacological factors are the most frequent cause of acute stent thrombosis. After the usual measures to restore flow in the infarct-related artery, it is important to consider the etiology of stent thrombosis as it pertains to further therapy and avoidance of recurrence. IVUS may identify factors such as an undersized stent, incomplete stent apposition, residual stenosis, or dissection and can guide subsequent treatment. The most common cause of acute stent thrombosis is nonadherence to DAPT; however, resistance to aspirin or thienopyridines and prothrombotic states such as congenital or acquired thrombophilic states (malignancy) are additional risk factors (834,835).

Given the poor prognosis of stent thrombosis and the uncertainties surrounding treatment, the importance of prevention must be emphasized. This includes ensuring compliance with DAPT and adequate stent sizing and expansion (836).

6.3. Restenosis: Recommendations

CLASS I

1. Patients who develop clinical restenosis after balloon angioplasty should be treated with BMS or DES if anatomic factors are appropriate and if the patient is able to comply with and tolerate DAPT (837). *(Level of Evidence: B)*
2. Patients who develop clinical restenosis after BMS should be treated with DES if anatomic factors are appropriate and the patient is able to comply with and tolerate DAPT (838–840). *(Level of Evidence: A)*

CLASS IIa

1. IVUS is reasonable to determine the mechanism of stent restenosis (495). *(Level of Evidence: C)*

CLASS IIb

1. Patients who develop clinical restenosis after DES may be considered for repeat PCI with balloon angioplasty, BMS, or DES containing the same drug or an alternative antiproliferative drug if anatomic factors are appropriate and the patient is able to comply with and tolerate DAPT (495). *(Level of Evidence: C)*

6.3.1. Background and Incidence

After balloon angioplasty, mechanisms contributing to restenosis include smooth muscle cell migration and proliferation, platelet deposition, thrombus formation, elastic recoil, and negative arterial remodeling. Stents block elastic recoil and negative remodeling, and the predominant mechanism for restenosis after stent implantation is neointimal hyperplasia. Restenosis rates vary, depending on whether angiographic restenosis (defined as >50% diameter stenosis at follow-up angiography) or clinical restenosis (symptomatic and requiring target-lesion revascularization or target-vessel revascularization) is measured, as well as on patient characteristics, coronary anatomy considerations, and device type (balloon angioplasty, BMS, or DES). The incidence of angiographic restenosis rates for uncomplicated lesions treated in RCTs ranges from 32% to 42% after balloon angioplasty (463,464) and from 16% to 32% after BMS (463,464), and is generally <10% after DES (454,841). Less than half of patients with angiographic restenosis present with symptomatic, clinically relevant restenosis at 1-year follow-up, and a pooled analysis of 6,186 patients from 6 trials of BMS showed target-lesion revascularization was performed in 12% and target-vessel revascularization in 14% at 1 year (842,843). Patients with clinical restenosis typically present with recurrent exertional angina, but 5% to 10% of patients present with acute MI and 25% with UA (844,845).

Factors associated with an increased risk of restenosis in various models include clinical setting (STEMI, ACS, daily angina), patient characteristics (diabetes, age <55 to 60 years, prior PCI, male sex, multivessel CAD), lesion location (unprotected left main, SVG), and procedural characteristics (minimum stent diameter ≤2.5 mm, total stent length ≥40 mm) (778,846).

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PCI strategies for treating restenosis after balloon angioplasty, BMS, and DES are reviewed in the following sections. In addition to repeat PCI, intensified medical therapy or CABG are often also reasonable strategies, dependent on initial treatment (e.g., balloon angioplasty, BMS), pattern of restenosis, likelihood of recurrent restenosis, ability to intensify medical therapy, suitability for CABG, and patient preference. Repeat PCI with BMS or DES is not appropriate if the patient is not able to comply with and tolerate DAPT.

6.3.2. Restenosis After Balloon Angioplasty

For clinical restenosis after balloon angioplasty, stent implantation is superior to repeat balloon angioplasty or atheroablation devices. The REST (REstenosis STent) study showed that target-lesion revascularization rates were 10% for stent-treated patients and 27% for balloon-treated patients ($p=0.001$) (837).

6.3.3. Restenosis After BMS

In-stent restenosis is classified according to these angiographic characteristics: Pattern I includes focal lesions ≤10 mm in length; Pattern II is in-stent restenosis >10 mm within the stent; Pattern III includes in-stent restenosis >10 mm extending outside the stent; and Pattern IV is totally occluded in-stent restenosis (847). Treatment of in-stent restenosis with balloon angioplasty, repeat BMS, or atheroablation devices for Patterns I to IV resulted in 1-year target-lesion revascularization rates of 19%, 35%, 50%, and 83%, respectively. For clinical restenosis after BMS, repeat stenting with DES is preferred. Studies have demonstrated lower recurrent restenosis rates with DES compared with BMS or vascular brachytherapy (495,838–840).

6.3.4. Restenosis After DES

Clinical restenosis after placement of DES is becoming increasingly common due to the large numbers of patients who have been treated with DES. The predominant angiographic pattern for DES in-stent restenosis is focal (≤10 mm in length). Several biologic, mechanical, and technical factors may contribute to DES in-stent restenosis, including drug resistance, hypersensitivity, stent underexpansion, stent strut fracture, nonuniform stent strut coverage, gap in stent coverage, and residual uncovered atherosclerotic lesion. IVUS might be considered to determine the cause for in-stent restenosis and help guide treatment strategy. Interventionists may treat focal DES restenosis with balloon angioplasty and treat nonfocal DES restenosis with BMS, CABG, or repeat DES with the same or an alternative antiproliferative drug (848,849). Small, observational cohort studies have demonstrated angiographic restenosis rates of 25% to 30% with repeat DES either with the same or an alternative drug (495,849,850). There are no RCTs, and the most appropriate treatment of restenosis of DES remains unknown.

6.4. Clinical Follow-Up

At the time of discharge, patients are instructed to contact their physician or seek immediate medical attention if symptoms recur. Most physicians will give the patient instructions on return to work and timing of return to full activities. The importance of strict compliance with aspirin and $P2Y_{12}$ inhibitor therapy is ideally emphasized to the patient at the time of discharge and during follow-up visits.

Secondary prevention measures after PCI are an essential part of long-term therapy, reducing both future morbidity and mortality associated with CAD, and are discussed in Section 6.5. A follow-up visit after PCI is usually scheduled to assess the patient's clinical status, the patient's compliance with secondary prevention therapies, and the success of secondary prevention measures (e.g., blood pressure control, low-density lipoprotein levels, smoking cessation). Routine, periodic stress testing of asymptomatic patients is not considered part of standard patient follow-up.

6.4.1. Exercise Testing: Recommendations

CLASS IIa

1. In patients entering a formal cardiac rehabilitation program after PCI, treadmill exercise testing is reasonable. *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. Routine periodic stress testing of asymptomatic patients after PCI without specific clinical indications should not be performed (795). *(Level of Evidence: C)*

Treadmill exercise testing before cardiac rehabilitation provides information about peak exercise capacity and heart rate, helping to stratify patients for the level of supervision during training, and seems reasonable for this purpose (851); nuclear imaging to assess ischemia in this context usually adds little.

The role of exercise testing to evaluate restenosis is much less certain. Although the presence of symptoms may not be a reliable means of detecting restenosis, there is no evidence that the detection of silent restenosis leads to improved outcome (852,853). Routine testing of all patients after PCI will also lead to many false-positive tests, particularly in the era of DES. As restenosis rates decline from 30% to 10%, the false-positive rate of stress imaging increases from 37% to 77% (854). A recent analysis of a national health insurance claims database and accompanying editorial find that stress testing after PCI is likely overused and rarely leads to repeat revascularization (855,856). In summary, there is no proven benefit or indication for routine periodic stress testing in patients after PCI, and, thus, it is not indicated (8,851). In cases in which there is a clear clinical indication for stress testing in a patient after PCI, exercise ECG alone is an insensitive predictor of restenosis (857,858); therefore, stress imaging is the preferred stress test (8). In cases of recurrent angina after PCI in which the pretest likelihood of restenosis is high and repeat revascularization based on symptoms is likely indicated, most

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practitioners will proceed directly to cardiac catheterization rather than first obtain stress imaging.

6.4.2. Activity and Return to Work

The timing of return to physical activity depends on the presenting condition as well as previous functional status. For STEMI, for example, daily walking is encouraged immediately, and driving can begin within 1 week after uncomplicated MI if allowed by local motor vehicle laws (859). Sexual activity usually can be resumed within days, provided exercise tolerance is adequate, normally assessed by the ability to climb a flight of stairs (859). Similar recommendations have been issued for UA/NSTEMI (860). Patients with UA who have undergone successful revascularization and are otherwise doing well may return to physical activity on an accelerated schedule, usually within a few days (860).

Return to work is more complex. Return to work rates after MI range from 63% to 94% and are confounded by factors such as job satisfaction, financial stability, and company policies (861). The physical demands and degree of stress of a particular job require that recommendations be individualized. In the PAMI-2 (Primary Angioplasty in Myocardial Infarction) trial, patients were encouraged to return to work 2 weeks after primary PCI for STEMI, and no adverse events were reported (862). In the RITA (Randomized Intervention Treatment of Angina) trial, revascularization with PCI led to earlier return to work compared with CABG, and subsequent employment rates were associated with relief of angina (105). Many practitioners use graded exercise treadmill testing to determine the safety of activity and return to work by measuring the metabolic equivalent of task (MET) level achieved and comparing that level to energy levels required to perform different activities (863).

6.4.3. Cardiac Rehabilitation: Recommendation

CLASS I

1. **Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for moderate- to high-risk patients for whom supervised exercise training is warranted (796–804). *(Level of Evidence: A)***

Participation in cardiac rehabilitation is associated with significant reductions in all-cause mortality (OR: 0.80, 95% CI: 0.68 to 0.93) and cardiac mortality (796,797). Reports from community-based surveys, which in general enroll older and higher-risk patients than clinical trials, have confirmed that participation in comprehensive rehabilitation is independently associated with a reduction in recurrent MI and reduced mortality (799). Cardiac rehabilitation is also associated with improvements in exercise tolerance, cardiac symptoms, lipid levels, cigarette smoking cessation rates (in conjunction with a smoking cessation program), stress levels, improved medical regimen compliance, and improved psychosocial well-being (800). Cardiac rehabilitation is cost-effective as well (864). Physician referral may be the most powerful predictor of patient participation in a cardiac rehabilitation program (865).

6.5. Secondary Prevention

The treatment of the patient does not end with PCI; secondary prevention measures are a critical component of patient management. Important secondary prevention measures were presented in detail in the "2006 AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease" (562) and have recently been updated in the "AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update" (805). The reader is referred to this document for detailed discussions of secondary prevention. Among the important recommendations are the following:

- Lipid management with lifestyle modification *(Class I; Level of Evidence: B)* (805–807) and statin therapy are recommended. *(Level of Evidence: A)* (344,806,808–810,810a) An adequate statin dose should be employed which reduces low-density lipoprotein cholesterol to <100 mg/dL AND achieves at least a 30% lowering of low-density lipoprotein cholesterol. *(Class I; Level of Evidence: C)* (806–810,810a) It is reasonable to treat patients with statin therapy which lowers low-density lipoprotein cholesterol to <70 mg/dL in very high-risk* patients. *(Class IIa; Level of Evidence: C)* (345,808–810,810a,811,812) Patients who have triglycerides ≥200 mg/dL should be treated with statins to lower non–high-density lipoprotein cholesterol to <130 mg/dL. *(Class I; Level of Evidence: B)* (344,809,810,866) In patients who are very high risk* and have triglycerides ≥200 mg/dL, a non–high-density lipoprotein cholesterol goal of <100 mg/dL is reasonable. *(Class IIa; Level of Evidence: C)* (344,809,810,866)
- Blood pressure control with lifestyle modification (*Class I; Level of Evidence: B)* (813–817) and pharmacotherapy (*Class I; Level of Evidence: A)* (805,813,818,819), with the goal of blood pressure <140/90 mm Hg.
- Diabetes management (e.g., lifestyle modification and pharmacotherapy), coordinated with the patient's primary care physician and/or endocrinologist. (*Class I; Level of Evidence: C)* (805)
- Advising patients on the need for complete smoking cessation. *(Class I; Level of Evidence: A)* (805,820–823)

*Presence of established cardiovascular disease plus 1) multiple major risk factors (especially diabetes), 2) severe and poorly controlled risk factors (especially continued cigarette smoking), 3) multiple risk factors of the metabolic syndrome (especially high triglycerides ≥200 mg/dL plus non–high-density lipoprotein cholesterol ≥130 mg/dL with low high-density lipoprotein cholesterol [<40 mg/dL]), and 4) acute coronary syndromes.

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7. Quality and Performance Considerations

7.1. Quality and Performance: Recommendations

CLASS I

1. Every PCI program should operate a quality-improvement program that routinely 1) reviews quality and outcomes of the entire program; 2) reviews results of individual operators; 3) includes risk adjustment; 4) provides peer review of difficult or complicated cases; and 5) performs random case reviews. *(Level of Evidence: C)*
2. Every PCI program should participate in a regional or national PCI registry for the purpose of benchmarking its outcomes against current national norms. *(Level of Evidence: C)*

PCI quality and performance considerations are defined by attributes related to structure, processes, and risk-adjusted outcomes. Structural attributes include elements such as equipment, supplies, staffing, institutional and operator-level volumes, and the availability of electronic medical records. Processes include strategies for the appropriate patient, protocols for pre- and postprocedural care, appropriate procedural execution and management of complications, and participation in databases and registries for benchmarking performance of the program and individual operator. Risk-adjusted outcomes are the end result of these structures and processes of care, and when available are more reliable measures of quality than the institutional and individual operator volumes discussed in Section 7.4.

PCI process and outcomes assessments can be used for internal quality-improvement efforts and public reporting. Public reporting of institutional risk-adjusted outcomes is becoming more common. Although operator-level outcomes can be assessed and risk adjusted, the results are much less reliable due to lack of statistical power resulting from lower volumes. Any public reporting must use statistical methods that meet the high criteria established by the AHA Work Group (867).

7.2. Training

The cognitive knowledge and technical skill required to perform PCI continue to grow. Details on the training required for interventional cardiology are found in the most recent ACCF Core Cardiology Training Statement (868).

7.3. Certification and Maintenance of Certification: Recommendation

CLASS IIa

1. It is reasonable for all physicians who perform PCI to participate in the American Board of Internal Medicine interventional cardiology board certification and maintenance of certification program. *(Level of Evidence: C)*

The American Board of Internal Medicine established interventional cardiology board certification in 1999 as an "added qualification" to the cardiovascular disease board certification. Since 1990 all certificates from the American Board of Internal Medicine are time limited for a 10-year period and require all diplomats to participate in maintenance of certification to maintain their board-certified status. Maintenance of certification in interventional cardiology requires physicians to document a minimum of 150 interventional cases over the 2 years before expiration of the current certification, complete self-assessment modules of their medical knowledge, participate in practice-based quality-improvement activities, and pass a secure, knowledge-based examination (869–871). For those who cannot meet the case volume requirement, an alternative option is to submit a log of 25 consecutive cases including patient characteristics and procedural outcomes. The maintenance of certification process is likely to change, as the American Board of Internal Medicine intends to evolve maintenance of certification from an episodic event that occurs once every 10 years to a more continuous process of continuous professional development.

7.4. Operator and Institutional Competency and Volume: Recommendations

CLASS I

1. Elective/urgent PCI should be performed by operators with an acceptable annual volume (≥75 procedures) at high-volume centers (>400 procedures) with on-site cardiac surgery (872,873). *(Level of Evidence: C)*
2. Elective/urgent PCI should be performed by operators and institutions whose current risk-adjusted outcomes statistics are comparable to those reported in contemporary national data registries. *(Level of Evidence: C)*
3. Primary PCI for STEMI should be performed by experienced operators who perform more than 75 elective PCI procedures per year and, ideally, at least 11 PCI procedures for STEMI per year. Ideally, these procedures should be performed in institutions that perform more than 400 elective PCIs per year and more than 36 primary PCI procedures for STEMI per year (872,874–877). *(Level of Evidence: C)*

CLASS IIa

1. It is reasonable that operators with acceptable volume (≥75 PCI procedures per year) perform elective/urgent PCI at low-volume centers (200 to 400 PCI procedures per year) with on-site cardiac surgery (872). *(Level of Evidence: C)*
2. It is reasonable that low-volume operators (<75 PCI procedures per year) perform elective/urgent PCI at high-volume centers (>400 PCI procedures per year) with on-site cardiac surgery. Ideally, operators with an annual procedure volume of fewer than 75 procedures per year should only work at institutions with an activity level of more than 600 procedures per year. Operators who perform fewer than 75 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures per year. *(Level of Evidence: C)*

CLASS IIb

1. The benefit of primary PCI for STEMI patients eligible for fibrinolysis when performed by an operator who performs fewer than 75 procedures per year (<11 PCIs for STEMI per year) is not well established. *(Level of Evidence: C)*

CLASS III: NO BENEFIT

1. It is not recommended that elective/urgent PCI be performed by low-volume operators (<75 procedures per year) at low-volume

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centers (200 to 400 procedures per year) with or without on-site cardiac surgery. An institution with a volume of fewer than 200 procedures per year, unless in a region that is underserved because of geography, should carefully consider whether it should continue to offer this service (872). *(Level of Evidence: C)*

Older observational evidence supported a volume-outcome relationship in PCI at both the institutional and operator level (873). However, this relationship is complicated and may be inconsistent across low-volume institutions or operators. More recent data on primary PCI suggest that operator experience may modify the volume-outcome relationship at the institutional level (876,878). Risk-adjusted outcomes remain preferable to institutional and individual operator volumes as quality measures.

Operator and hospital volume recommendations have been carried over from the 2005 PCI guideline. However, the writing committee recognizes that these volume recommendations are controversial. In addition, after extensive review of all relevant data, the writing committee believes that the LOE in support of all the above recommendations is best categorized as LOE C rather than LOE B as it has been in prior guidelines for some recommendations. We encourage the ACCF/AHA/ACP Clinical Competence and Training writing group for PCI and other expert writing groups to review this issue so that new recommendations can be considered by the next PCI guideline writing committee.

7.5. Participation in ACC NCDR or National Quality Database

Assessment of PCI quality and outcomes is important both at the level of the entire program and at the level of the individual physician. This requires collection of clinical and procedural data for PCI that allows regular comparison of risk-adjusted outcomes and complications with national benchmarks. The ACC NCDR CathPCI Registry is an example of a national registry to fulfill the goals of assessing and benchmarking quality and outcomes.

8. Future Challenges

Although this latest guideline reflects significant advancements in the field of PCI, there remain future challenges to the formulation and updating of guidelines for PCI. The proliferation of studies comparing the many newer drugs and devices with older therapies (or other newer therapies), often using different or novel study endpoints, endpoint definitions, and noninferiority designs, pose increasing challenges to objectively evaluating newer therapies and generating recommendations for their use. Numerous potential advances in the field of PCI, including intracoronary stem cell infusions for chronic and acute ischemic heart disease, designer drugs, novel intracoronary imaging technologies such as optical coherence tomography and virtual histology, new stent composition and designs (e.g., drug-eluting, biodegradable, bifurcation), and drug-eluting balloons were considered for formal evaluation by the current writing committee, but it was thought that there were insufficient data at present to formulate any formal recommendations on these topics. These and other emerging technologies and treatments will need to be addressed in future PCI guidelines.

Finally, with this proliferation of new technology, the amount of data generated in the evaluation of these potential therapeutic advances will grow dramatically, adding significant challenges to future guideline generations. Of note, the Web site www.clinicaltrials.gov currently lists several hundred PCI-related clinical trials.

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Key Words: ACCF/AHA Practice Guidelines ■ acute coronary syndromes ■ anticoagulants ■ antiplatelet agents ■ arrhythmias, cardiac ■ coronary angiography ■ coronary artery revascularization interventions: stents ■ drug therapy ■ drug delivery systems ■ heart diseases ■ myocardial revasularization ■ platelet aggregation inhibitor ■ ultrasound.

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APPENDIX 1. AUTHOR RELATIONSHIPS WITH INDUSTRY AND OTHER ENTITIES (RELEVANT)—2011 ACCF/AHA/SCAI GUIDELINE FOR PERCUTANEOUS CORONARY INTERVENTION

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G. B. John Mancini	Official Reviewer—ACCF Board of Governors	• GlaxoSmithKline • Merck • Pfizer • Sanofi-aventis	None	None	• Merck*	None	None

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*Significant relationship. †No financial benefit.

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; DSMB, data safety and monitoring board; NHLBI, National Heart, Lung, and Blood Institute; NIH, National Institutes of Health; SCAI, Society for Cardiovascular Angiography and Interventions; and TIMI, Thrombolysis In Myocardial Infarction.

APPENDIX 3. ABBREVIATION LIST

ACS = acute coronary syndromes
AKI = acute kidney injury
BMS = bare-metal stent(s)
CABG = coronary artery bypass graft surgery
CAD = coronary artery disease
CKD = chronic kidney disease
CTO = chronic total occlusion
DAPT = dual antiplatelet therapy
DES = drug-eluting stent(s)
ECG = electrocardiogram
EF = ejection fraction
EPD = embolic protection device
FDA = U.S. Food and Drug Administration
FFR = fractional flow reserve
GDMT = guideline-directed medical therapy
GI = gastrointestinal
GP = glycoprotein
IABP = intra-aortic balloon pump
IV = intravenous
IVUS = intravascular ultrasound
LAD = left anterior descending
LIMA = left internal mammary artery
LV = left ventricular
LVEF = left ventricular ejection fraction
MACE = major adverse cardiac event
MI = myocardial infarction
MRI = magnetic resonance imaging
NCDR = National Cardiovascular Data Registry
PCI = percutaneous coronary intervention
PPI = proton pump inhibitor
RCT = randomized controlled trial
SIHD = stable ischemic heart disease
STEMI = ST-elevation myocardial infarction
SVG = saphenous vein graft
TIMI = Thrombolysis In Myocardial Infarction
TMR = transmyocardial laser revascularization
UA/NSTEMI = unstable angina/non–ST-elevation myocardial infarction
UFH = unfractionated heparin

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APPENDIX 4. ADDITIONAL TABLES/FIGURES

Appendix 4A. The NCDR CathPCI Risk Score System

Variable	Scoring Response Categories				Risk Score Calculation	
					Total Points	Risk of In-Patient Mortality (%)
Age	<60	≥60, <70	≥70, <80	≥80	0	0.0
	0	4	8	14	5	0.1
Cardiogenic shock	No	Yes			10	0.1
	0	25			15	0.2
Prior CHF	No	Yes			20	0.3
	0	5			25	0.6
Peripheral vascular disease	No	Yes			30	1.1
	0	5			35	2.0
Chronic lung disease	No	Yes			40	3.6
	0	4			45	6.3
GFR	<30	30-60	60-90	>90	50	10.9
	18	10	6	0	55	18.3
NYHA functional class IV	No	Yes			60	29.0
	0	4			65	42.7
PCI status (STEMI)	Elective	Urgent	Emergent	Salvage	70	57.6
	12	15	20	38	75	71.2
PCI status (no STEMI)	Elective	Urgent	Emergent	Salvage	80	81.0
	0	8	20	42	85	89.2
					90	93.8
					95	96.5
					100	98.0

CathPCI indicates catheterization percutaneous coronary intervention; CHF, congestive heart failure; GFR, glomerular filtration rate; NCDR, National Cardiovascular Data Registry; NYHA, New York Heart Association; and STEMI, ST-elevation myocardial infarction. Reproduced with permission from Peterson et al. (236).

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Appendix 4B. The SCAI Lesion Classification System

Type I lesions (highest success expected, lowest risk)

1. Does not meet criteria for C lesion
2. Patent

Type II lesions

1. Meets any of these criteria for ACC/AHA C lesion
   - Diffuse (>2 cm length)
   - Excessive tortuosity of proximal segment
   - Extremely angulated segments, >90°
   - Inability to protect major side branches
   - Degenerated vein grafts with friable lesions
2. Patent

Type III lesions

1. Does not meet criteria for C lesion
2. Occluded

Type IV lesions

1. Meets any of these criteria for ACC/AHA C lesion
   - Diffuse (>2 cm length)
   - Excessive tortuosity of proximal segment
   - Extremely angulated segments, >90°
   - Inability to protect major side branches
   - Degenerated vein grafts with friable lesions
   - Occluded for >3 mo
2. Occluded

ACC indicates American College of Cardiology; AHA, American Heart Association; and SCAI, Society for Cardiovascular Angiography and Interventions. Reprinted with permission from Krone et al. (879).

Appendix 4C. Strategies to Reduce Radiation Exposure to Patient and Operator

Precautions to minimize exposure to patient and operator

- Use radiation only when imaging is necessary to support clinical care
- Minimize use of cine
- Minimize use of steep angles of x-ray beam
- Minimize use of magnification modes
- Minimize frame rate of fluoroscopy and cine
- Keep the image receptor close to the patient
- Utilize collimation to the fullest extent possible
- Monitor radiation dose in real time to assess patient risk-benefit during procedure

Precautions to specifically minimize exposure to operator

- Use and maintain appropriate protective garments
- Maximize distance of operator from x-ray source and patient
- Keep above-table and below-table shields in optimal position at all times
- Keep all body parts out of field of view at all times

Precautions to specifically minimize exposure to patient

- Keep table height as high as comfortably possible for operator
- Vary imaging beam angle to minimize exposure to any single skin area
- Keep patient's extremities out of beam

Appendix 4D. Patient Care Consideration Based on Procedural Radiation Dose

$K_{a,r}$*	P_{KA}†	FT‡	Action
>5 Gray	>500 Gray cm^2	>60 min	Physician charts documentation about why exposure at this level occurred, documents whether multiple skin entry angles were used, assesses risk, educates patient about potential for skin injury, and arranges for appropriate follow-up within 30 d. Phone calls may be sufficient with an office visit arranged if issues/questions arise or a potential tissue injury is suspected.
≥10 Gray			Physician contacts radiation safety officer/medical physicist. The radiation safety officer/medical physicist should perform a detailed analysis of PSD. Document a) FOV, b) skin entrance port number, c) known geometry, with a "rough" geometric setup required. Educate patient about the potential for skin injury and document this in chart. Schedule an office visit in 2 to 4 wk.
PSD§ >15 Gray			If calculated PSD is indeed >15 Gray, the physician and/or radiation safety officer/medical physicist should contact hospital risk management within 24 h. Report the event to the Joint Commission and as needed to the appropriate State Department of Health.

*$K_{a,r}$ is total air kerma at reference point; †P_{KA} is air kerma-area product; ‡FT is total fluoroscopy time, does not include cine; §PSD is peak skin dose, which requires calculations made by a qualified physicist.

FOV indicates field of view; and FT, fluoroscopy time.

Adapted with permission from Chambers et al. (317).

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Appendix 4E. General Considerations in Deciding Between Early Invasive Strategy and Initial Conservative Strategy

Early Invasive Strategy Generally Preferred	Initial Conservative Strategy Generally Preferred or Reasonable
• Recurrent angina or ischemia at rest or with low-level activities despite intensive medical therapy • Elevated cardiac biomarkers (TnT or TnI) • New or presumably new ST-segment depression • Signs or symptoms of heart failure • Hemodynamic instability • High-risk score (e.g., GRACE, TIMI) • Sustained ventricular tachycardia • PCI within 6 mo • Prior CABG • Diabetes mellitus • Mild to moderate renal dysfunction • Reduced LV function (LVEF <40%)	• Low-risk score (e.g., GRACE, TIMI) • Absence of high-risk features • High risk for catheterization-related complications • Patient not a candidate for revascularization (with either PCI or CABG) • Patient prefers conservative therapy

CABG indicates coronary artery bypass graft surgery; GRACE, Global Registry of Acute Coronary Events; LV, left ventricular; LVEF, left ventricular ejection fraction; PCI, percutaneous coronary intervention; TIMI, Thrombolysis In Myocardial Infarction; TnI, troponin I; and TnT, troponin T.

Appendix 4F. Agents for Procedural Sedation and Analgesia

Drug	Clinical Effects	Dose	Onset	Duration	Comments
Midazolam	Sedation, anxiolysis. No analgesia.	Initial 0.5 to 1 mg IV, then titrated.	2 to 3 min	45 to 60 min	Reduce dose when used in combination with opioids. May produce paradoxical excitement. Reversible with flumazenil.
Fentanyl	Analgesia	50 mcg IV. May repeat every 3 min, titrate to effect.	3 to 5 min	30 to 60 min	Reduce dosing when combined with benzodiazepines. Reversible with naloxone.
Etomidate	Sedation, anxiolysis. No analgesia.	Sedation: 0.1 mg/kg IV; repeat if inadequate response.	<1 min	5 to 15 min	Respiratory depression may occur; institutional guidelines vary about administration to nonintubated patients by nonanesthesiologists. May cause myoclonus, nausea, and vomiting. Adrenocortical suppression occurs but is rarely of clinical significance. Not reversible.
Propofol	Sedation, anxiolysis. No analgesia.	Load 1 mg/kg IV; may administer additional 0.5 mg/kg doses as needed to enhance or prolong sedation.	<1 min	5 to 15 min	Frequent hypotension and respiratory depression; institutional guidelines vary concerning administration to nonintubated patients by nonanesthesiologists. Avoid with egg or soy allergies. Not reversible.
Reversal Agents					
Naloxone	Opioid reversal	0.4 to 2 mg IV	2 min	20 to 40 min	If shorter acting than reversed drug, serial doses may be required.
Flumazenil	Benzodiazepine reversal	0.2 mg IV. May repeat every 1 min up to 1 mg.	1 to 2 min	30 to 60 min	If shorter acting than reversed drug, serial doses may be required. Do not use in patients receiving long-term benzodiazepines, cyclosporine, isoniazid, lithium, propoxyphene, theophylline, or tricyclic antidepressants.

IV indicates intravenous.

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2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention

American College of Cardiology Foundation, American Heart Association Task Force on Practice Guidelines, Society for Cardiovascular Angiography and Interventions, Glenn N. Levine, Eric R. Bates, James C. Blankenship, Steven R. Bailey, John A. Bittl, Bojan Cercek, Charles E. Chambers, Stephen G. Ellis, Robert A. Guyton, Steven M. Hollenberg, Umesh N. Khot, Richard A. Lange, Laura Mauri, Roxana Mehran, Issam D. Moussa, Debabrata Mukherjee, Brahmajee K. Nallamothu, and Henry H. Ting

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EuroIntervention

The SYNTAX Score: an angiographic tool grading the complexity of coronary artery disease

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Introduction

Optimal revascularization strategy in patients with coronary artery disease remains a subject of debate between interventional cardiologists and surgeons. Numerous large scale randomized trials addressed this issue comparing coronary artery bypass grafting (CABG) with percutaneous coronary intervention (PCI) in patients with multivessel disease (MVD). Initially these trials compared multivessel balloon angioplasty with CABG[1-6] and in a later period multivessel stenting with CABG[7-11]. These studies clearly demonstrated that there was no difference between the two therapeutic modalities regarding mortality and non fatal myocardial infarction but patients treated with balloon angioplasty or stenting required more often repeat revascularization procedures related to restenosis[12,13].

Clearly stenting reduced the gap in the event free survival rate between the two revascularization strategies from 32% in CABRI trial (91% versus 59% in favour of CABG) to 14% in ARTS I trial (89% versus 75%) but still surgery remained the gold standard for patients with MVD with an event free survival rate around 90%[14].

Recently the drug eluting stents were introduced and proven to be very effective in reducing restenosis and the incidence of repeat revascularisation[15-18]. In the recently conducted ARTS II trial the sirolimus eluting stents were compared with historical CABG data from the ARTS I trial in patients with MVD. The incidence of major adverse cardiac events was comparable in both approaches, even though the number of vessels and lesions treated were higher than in the previous trials[19]. However, it has been argued that despite the fact that patients with two or three vessel disease have been included in the aforementioned trials, in the "real world" both interventional cardiologists and surgeons are often confronted with more complex anatomy. Numerous exclusion criteria and disagreement between the surgeons and the interventional cardiologists allowed only 2%-12% of the patients screened to be randomized[13].

Another characteristic of these trials was the heterogeneity in the complexity of coronary artery disease of the patients enrolled[13]. For example, a patient with distal a left-main stem trifurcation lesion in combination with an occluded right coronary artery is pooled together with a patient with three focal lesions in the mid portions of the three coronary arteries. Both are characterised as routinely named “3-vessel disease”, despite the fact that the first patient represents a greater therapeutic challenge for the interventional cardiologist and has completely different prognosis compared to the second patient regardless of the revascularization strategy; percutaneous or surgical. The absence of grading of the severity of coronary artery disease and the lack of comparison of lesion complexity based on pre-treatment angiographic criteria between various groups severely limits the interpretation of the results of these trials.

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Thus, for the selection of the optimal revascularization strategy for patients with three vessel and/or left main stem disease there are three major requirements:

1. The conductance of an "all comer" (no exclusion criteria) study in such patients.
2. Consensus between the interventional cardiologist and the cardiothoracic surgeon for the treatment plan.
3. The quantification of the complexity of coronary artery disease, taking into account not only the number of significant lesions and their location, but also the complexity of each lesion independently.

The SYNTAX (SYNergy between PCI with TAXUS™ and Cardiac Surgery) study was organized as an all comer study for patients with significant lesions in the left main stem and/or the three epicardial coronary arteries. It will be comprised of a randomized arm and two registries for patients that are not suitable for one of the two revascularization strategies. Patients who have a preference for one of the treatment strategies or patients in whom medical treatment is suggested they will be included in the screening log.

The SYNTAX score has been developed for this study to prospectively characterise the coronary vasculature with respect to the number of lesions and their functional impact, location, and complexity. Higher SYNTAX scores, indicative of more complex disease are hypothesized to represent a bigger therapeutic challenge and to have potentially worse prognosis.

Pre-existing classifications

The SYNTAX score has been developed based on the following:

1. The AHA classification of the coronary tree segments modified for the ARTS study
2. The Leaman score
3. The ACC/AHA lesions classification system
4. The total occlusion classification system
5. The Duke and ICPS classification systems for bifurcation lesions
6. Consultation of experts

Each of these classifications has been focusing on specific functional and anatomical parameters of the lesions. Thus, the development of a global classification system that would take into account all the variables was necessary.

Definition of the coronary tree segments

The definition of the coronary tree segments is based on the classification proposed by the AHA[20] and modified for the ARTS I and II trials[21]. By this system the arterial tree is divided in 16 segments (Figure 1) and as such has been adopted in the SYNTAX score.

Leaman score[22]

The 'Leaman score' is based on the severity of luminal diameter narrowing and weighed according to the usual blood flow to the left ventricle in each vessel or vessel segment. In a right dominant system, the right coronary artery (RCA) supplies approximately 16% and the left coronary artery (LCA) 84% of the flow to the left ventricle (LV). This 84% is normally directed for 66% to the left anterior descending artery (LAD), and for 33% into the left circumflex coronary artery (LCX). Thus, the Left Main (LM) supplies approximately 5 times, the LAD approximately 3,5 times (84/16 x 0.66) and the circumflex 1,5 times as much blood as the RCA to the left ventricle. In a left dominant system the RCA does not contribute to the blood supply of the ventricle. Thus the LM supplies 100% of the flow to the LV. The RCA contribution of blood flow to the LV is now supplied by the LCX. Hence the LAD provides 58% (weighing factor 3.5) and the LCX 42% (weighing factor 2.5) of the total flow to the LV. Using the same principle of relative blood supply to the LV all coronary segments has been given a weighing factor factor, Table 1.

The contribution of each coronary segment to the blood flow to the LV is used as a multiplication factor for the calculation of the Leaman score and as such has been transferred to the SYNTAX score.

A lesion is defined as significant when it causes (50% reduction in luminal diameter by visual assessment in vessels (1.5mm. Less severe lesions should not be included in the SYNTAX score. The percent diameter stenosis is not considered in the algorithm. Distinction has been made only between occlusive (100% diameter stenosis) and non occlusive (50-99% diameter stenosis) disease. A multiplication factor of 2 is used for non-occlusive lesions and 5 for occlusive lesions reflecting the difficulty of the percutaneous treatment, Table 1. Importantly, all other adverse lesion characteristics considered in the SYNTAX score have an additive value, Table 2.

Table 1. Segment weighing factors

Segment No		Right dominance	Left dominance
1	RCA proximal	1	0
2	RCA mid	1	0
3	RCA distal	1	0
4	Posterior descending artery	1	n.a.
16	Posterolateral branch from RCA	0.5	n.a.
16a	Posterolateral branch from RCA	0.5	n.a.
16b	Posterolateral branch from RCA	0.5	n.a.
16c	Posterolateral branch from RCA	0.5	n.a.
5	Left Main	5	6
6	LAD proximal	3.5	3.5
7	LAD mid	2.5	2.5
8	LAD apical	1	1
9	First diagonal	1	1
9a	First diagonal[a]	1	1
10	Second diagonal	0.5	0.5
10a	Second diagonal[a]	0.5	0.5
11	Proximal circumflex artery	1.5	2.5
12	Intermediate/ anterolateral artery	1	1
12a	Obtuse marginal[a]	1	1
12b	Obtuse marginal[b]	1	1
13	Distal circumflex artery	0.5	1.5
14	Left posterolateral	0.5	1
14a	Left posterolateral[a]	0.5	1
14b	Left posterolateral[b]	0.5	1
15	Posterior descending	n.a.	1

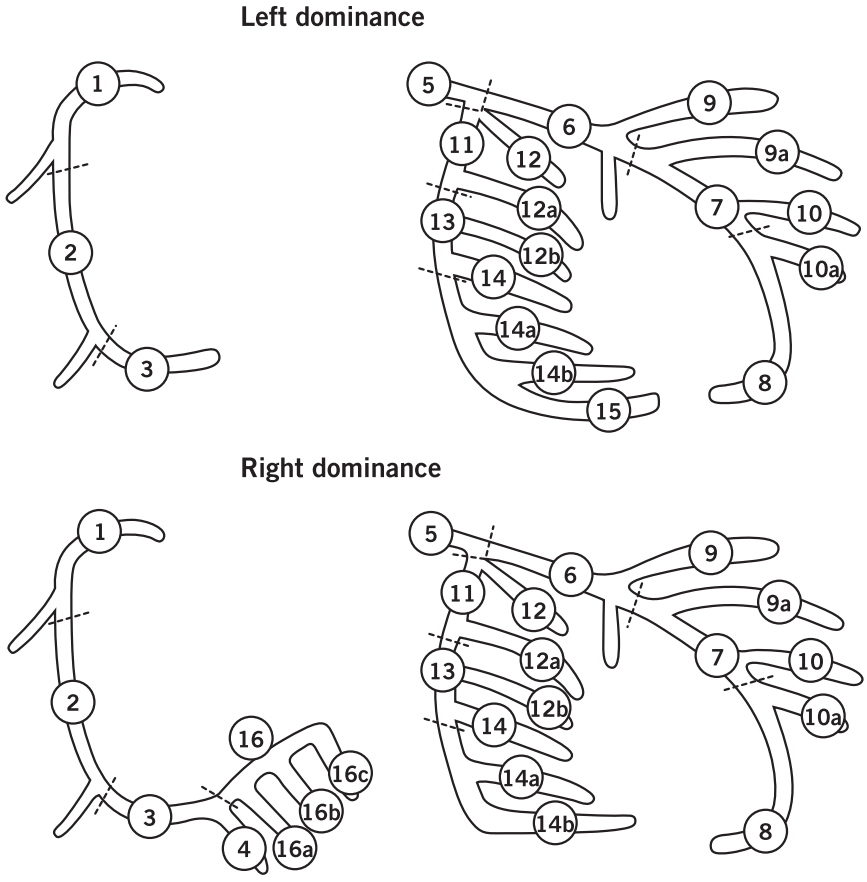

Figure 1. Definition of the coronary tree segments

1. *RCA proximal: From the ostium to one half the distance to the acute margin of the heart.*

2. *RCA mid: From the end of first segment to acute margin of heart.*

3. *RCA distal: From the acute margin of the heart to the origin of the posterior descending artery.*

4. *Posterior descending artery: Running in the posterior interventricular groove.*

16. *Posterolateral branch from RCA: Posterolateral branch originating from the distal coronary artery distal to the crux.*

16a. *Posterolateral branch from RCA: First posterolateral branch from segment 16.*

16b. *Posterolateral branch from RCA: Second posterolateral branch from segment 16.*

16c. *Posterolateral branch from RCA: Third posterolateral branch from segment 16.*

5. *Left main: From the ostium of the LCA through bifurcation into left anterior descending and left circumflex branches.*

6. *LAD proximal: Proximal to and including first major septal branch.*

7. *LAD mid: LAD immediately distal to origin of first septal branch and extending to the point where LAD forms an angle (RAO view). If this angle is not identifiable this segment ends at one half the distance from the first septal to the apex of the heart.*

8. *LAD apical: Terminal portion of LAD, beginning at the end of previous segment and extending to or beyond the apex.*

9. *First diagonal: The first diagonal originating from segment 6 or 7.*

9a. *First diagonal a: Additional first diagonal originating from segment 6 or 7, before segment 8.*

10. *Second diagonal: Originating from segment 8 or the transition between segment 7 and 8.*

10a. *Second diagonal a: Additional second diagonal originating from segment 8.*

11. *Proximal circumflex artery: Main stem of circumflex from its origin of left main and including origin of first obtuse marginal branch.*

12. *Intermediate/anterolateral artery: Branch from trifurcating left main other than proximal LAD or LCX. It belongs to the circumflex territory.*

12a. *Obtuse marginal a: First side branch of circumflex running in general to the area of obtuse margin of the heart.*

12b. *Obtuse marginal b: Second additional branch of circumflex running in the same direction as 12.*

13. *Distal circumflex artery: The stem of the circumflex distal to the origin of the most distal obtuse marginal branch, and running along the posterior left atrioventricular groove. Caliber may be small or artery absent.*

14. *Left posterolateral: Running to the posterolateral surface of the left ventricle. May be absent or a division of obtuse marginal branch.*

14a. *Left posterolateral a: Distal from 14 and running in the same direction.*

14b. *Left posterolateral b: Distal from 14 and 14 a and running in the same direction.*

15. *Posterior descending: Most distal part of dominant left circumflex when present. It gives origin to septal branches. When this artery is present, segment 4 is usually absent.*

Table 2. Lesions adverse characteristic scoring

Diameter reduction*		
- Total occlusion		x5
- Significant lesion (50-99%)		x2
Total occlusion (TO)		
- Age >3months or unknown		+1
- Blunt stump		+1
- Bridging		+1
- First segment visible beyond TO		+1/ per non-visible segment
- Side branch (SB)	- Yes, SB <1.5mm**	+1
	- Yes, both SB < & ≥ 1.5mm	+1
Trifurcations		
- 1 diseased segment		+3
- 2 diseased segments		+4
- 3 diseased segments		+5
- 4 diseased segments		+6
Bifurcations		
- Type A, B, C		+1
- Type D, E, F, G		+2
- Angulation <70°		+1
Aorto ostial stenosis		+1
Severe tortuosity		+2
Length > 20mm		+1
Heavy calcification		+2
Thrombus		+1
"Diffuse disease"/small vessels		+1/ per segment number

x: multiplication
+: addition

* In the SYNTAX algorithm there is no question for % luminal diameter reduction. The lesions are considered as significant (50-99% luminal diameter reduction) or occlusive.

** If all the side branches are 1.5mm in diameter, no points are added since the lesion is considered as a bifurcation and it will be scored as such.

Multiple-tandem lesions

If multiple lesions are less than 3 vessel reference diameters apart (tandem lesion), these lesions are scored as one lesion. However, lesions at a greater distance from each other (more than 3 vessel reference diameters), are considered as separate lesions.

ACC/AHA lesion classification system[23]

This lesion classification system is based on parameters, such as length, eccentricity, angulation, calcification, involvement of side branches, thrombus and severity of stenosis. Lesions are classified as Type A, (high success and low risk), Type B (moderate success and moderate risk) or Type C (low success and high risk).
The majority of these individual parameters have been incorporated in the SYNTAX score (Table 2). Although the ACC/AHA system takes into account the total occlusions and the bifurcation lesions classifying them as a high-risk, it is not considered as detailed enough to adequately quantify their complexity.

Total occlusion classification system[24]

A lesion is characterized as a total occlusion when no antegrade flow is visible distal to the obstruction. Segments distal to the occlusion may be filled by bridging, ipsilateral or contra-lateral collaterals. Parameters suggested in this system such as age of the occlusion more than three months, presence of side-branch at the site of the occlusion and their size, a blunt stump, presence of bridging collaterals and occlusion length have been incorporated into the SYNTAX score, Table 2.
The length of the obstructed segment is calculated by measuring the distance between the stump of the occlusion and the first segment beyond the occlusion, visualized by ante-grade or retrograde collateral flow, Figure 2. The age of the total occlusion is scored based on history of previous infarct, worsening symptoms, previous angiographic or electrocardiographic data. In case that this information is absent the age of total occlusion is scored as unknown.

Duke and ICPS bifurcation lesion classification systems

Bifurcation is defined as a junction of a main vessel and a side branch (with a minimal diameter of 1.5mm). A lesion is scored as a bifurcation, if the main vessel and/or the side branch have a narrowing. Bifurcation lesions *not involving the ostium* of the side branch are classified as type A if the lesion in the main vessel is proximal, type B distal and type C both proximal and distal to the side branch. Bifurcation lesions *involving the ostium* of the side branch are classified as type F if the lesion in the main branch is proximal, type G distal and type D both proximal and distal to the side branch. As plaque shift can occur even when only the ostium of a side branch is narrowed, such a lesion is also considered as a bifurcation (type E) (Figure 3). Bifurcations are only considered for the following segment junctions: 5/6/11, 6/7/9, 7/8/10, 11/13/12a, 13/14/14a and 3/4/16 and 13/14/15 in case of left dominance. The above mentioned classification is a combination of the Duke[25] and the ICPS[26] classification bifurcation systems, each proposing 6 types of bifurcations. Type G was missing from the former while type D from the latter. The combination of both constitutes the SYNTAX classification with 7 types.
One lesion characteristic added to the bifurcation lesion classification is the angulation less than 70 degrees of the side branch with the distal main vessel. Despite the fact that this represents a less technical challenge, it is regarded as an adverse lesion characteristic due to the fact that the smaller this angle is the more difficult it will be to cover the ostium of the side branch when stenting is necessary, Figure 4.

Trifurcation lesions

Trifurcation is a junction of three branches, one main vessel and two side branches (with a minimal diameter of 1.5mm). In a trifurcation, one, two, three or four of the involved segments can be diseased. The most common example of a trifurcation is at the division of LM into the LAD, LCX, and an intermediate branch. Trifurcations are only scored for the following segment junctions: 3/4/16/16a, 5/6/11/12, 11/12a/12b/13, 6/7/9/9a and 7/8/10/10a, Table 2.

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Aorto-ostial lesions

A lesion is classified as aorto-ostial when it is located immediately at the origin of the coronary arteries from the aorta. It applies only to segments 1 and 5. In case of absence of a LM (double ostium of the Left Coronary Artery), the segments 6 of the LAD and 11 of the LCX originate directly from the aorta and consequently may also involve aorto-ostial lesions. Aorto-ostial location is regarded as an adverse characteristic since the treatment of such lesions is technically more challenging.

Diffuse disease/Small vessels

Present when at least 75% of the length of the segment distal to the lesion has a vessel diameter of <2mm, irrespective of the presence or absence of disease at that distal segment. It is a parameter introduced to reflect the more challenging creation of a surgical anastomosis in small or diseased vessels.

The SYNTAX score algorithm (Table 3)

The SYNTAX score is calculated by a computer program consisting of sequential and interactive self-guided questions. The algorithm consists of twelve main questions. They can be divided in two groups:
The first three determine the dominance, the total number of lesions and the vessel segments involved per lesion and they appear once. The maximum number of lesions allowed is twelve and each lesion is characterized by a number, 1 to 12. The lesions will be scored in the numerical order inserted in question 3. Each lesion can involve one or more segments. In this case each vessel segment involved contributes to the lesion scoring. There is no limit in the number of segments involved per lesion.
The last nine questions refer to adverse lesion characteristics and are repeated for each lesion.
The question referring to a total occlusion is the first one. If a total occlusion is scored, answers must be given to detailed sub-questions. The last of these sub-questions refers to the presence or absence of side branches and their size. If there are no side branches or if their diameter is <1.5 mm then the questions related to the trifurcation and bifurcation lesions will be automatically skipped since vessels <1.5 mm are not considered large enough for treatment either with PCI or CABG. If side branches with diameter 1.5 mm are involved then the lesion is considered as both total occlusion and bifurcation lesion and the algorithm will continue with all the questions. The same is the case for non-occlusive lesions. With the exception of the selection of the type in case of a bifurcation or a trifurcation lesion all the other questions of the algorithm can be answered by selecting “yes” or “no”.

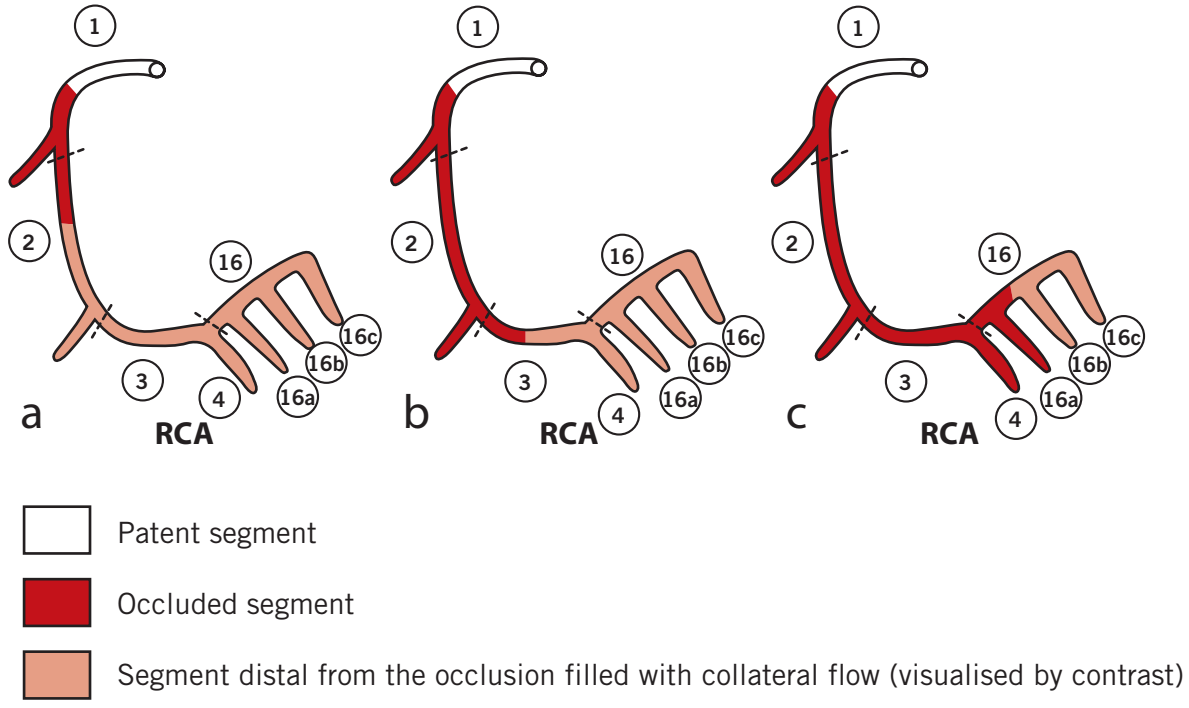


Figure 2. Total occlusion length assessment
a) Total occlusion involving segments 1 and 2. Segments 2,3,4,16,16a,16b,16c are filled by antegrade or retrograde collateral flow (visualised by contrast).
b) Total occlusion involving segments 1, 2 and 3. Segments 3,4,16,16a,16b,16c are filled by antegrade or retrograde collateral flow (visualised by contrast).
c) Total occlusion involving segments 1, 2, 3, 4, 16 and 16a Segments 16,16b,16c are visualized by antegrade or retrograde collateral flow (visualised by contrast).

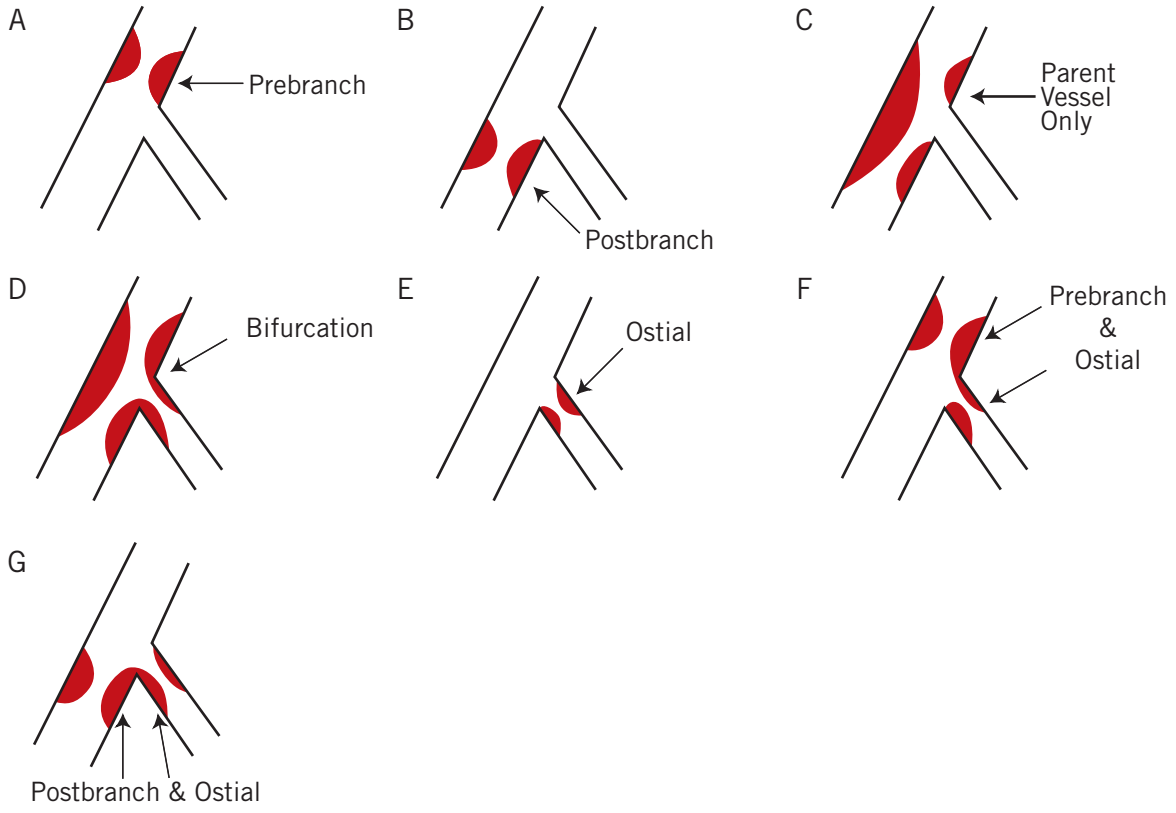


Figure 3. Bifurcation classification (modified from Duke and ICPS classifications systems)
Type A: *Pre-branch stenosis not involving the ostium of the side branch.*
Type B: *Post side branch stenosis of the main vessel not involving the origin of the side branch.*
Type C: *Stenosis encompassing the side branch but not involving its ostium.*
Type D: *Stenosis involving the main vessel and ostium of the side branch.*
Type E: *Stenosis involving only the ostium of the side branch*
Type F: *Stenosis directly involving the main vessel (pre-side branch) and the ostium of the side branch.*
Type G: *Stenosis directly involving the main vessel (post-side branch) and the ostium of the side branch.*

The last question of the algorithm, diffuse disease/small vessels, is the only one non-lesion-specific since it is related to vessel anatomy beyond the stenosis. In case of positive answer all the coronary segments beyond the one under scoring will appear allowing the selection of these fulfilling the criteria for diffuse disease/small vessels. It is quoted once (the first time selected) per coronary territory (RCA, LM, LAD, LCX). If for example this question is answered during a LM lesion scoring it will not reappear for lesions in the LAD or LCX territory. The same is the case for multiple lesions in the same vessel. Since the lesions are scored in the numerical order inserted in question 3, a scoring in "anatomical order" from proximal to distal is advised for each coronary artery. For example a lesion in segment 2 of the RCA should be scored before a lesion located in more distal segments.

An important characteristic of the SYNTAX score is that it is lesion based. For each lesion a separate score is calculated. The total SYNTAX score is derived from the summation of these individual scorings. After the completion of the algorithm a report is automatically generated summarizing all the adverse characteristics, and the individual scoring of each lesion as well as the total SYNTAX score. Two examples of the SYNTAX score calculation are presented in Figures 5, 6. Both patients have significant stenosis in all three

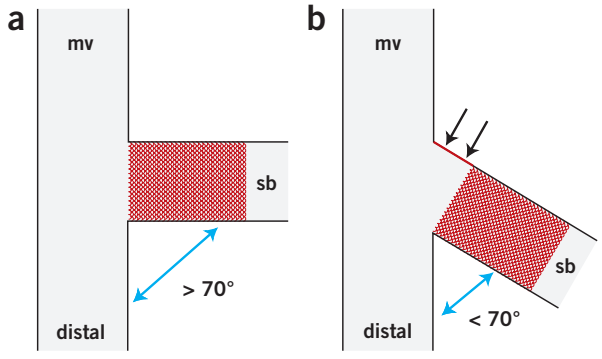


Figure 4.
a) An example of a bifurcation lesion with a wide angle (>70 degrees) between the side branch and the distal main vessel. Although technical challenging sometimes, the stent can fully cover both the proximal and distal rims of the side branch ostium. b) An example of a bifurcation with a steep angle (<70 degrees) between the side branch and the distal main vessel. Side branch stenting might be technically less challenging compared to the previous anatomy but when the stent is placed to cover the distal rim of the ostium the proximal rim will remain uncovered (red line with arrows). If the stent is placed to cover the proximal rim it will protrude into the main vessel distally. mv denotes main vessel, sb denotes side branch.

Table 3. The SYNTAX score algorithm

1. Dominance

2. Number of lesions

3. Segments involved per lesion

Lesion Characteristics

4. Total occlusion

i. Number of segments involved
ii. Age of the total occlusion (>3 months)
iii. Blunt Stump
iv. Bridging collaterals
v. First segment beyond the occlusion visible by antegrade or retrograde filling
vi. Side branch involvement

5. Trifurcation

i. Number of segments diseased

6. Bifurcation

i. Type
ii. Angulation between the distal main vessel and the side branch <70°

7. Aorto-ostial lesion

8. Severe tortuosity

9. Length >20mm

10. Heavy calcification

11. Thrombus

12. Diffuse disease/small vessels

i. Number of segments with diffuse disease/small vessels

The SYNTAX score is calculated by a computer program consisting of sequential and interactive self-guided questions. All the below mentioned definitions are projected in a side window when the signal (i) indicating information, available for each questions, is pointed with the cursor.

Definitions:

Dominance: a) Right dominance: the posterior descending coronary artery is a branch of the right coronary artery (segment 4). b) Left dominance: the posterior descending artery is a branch of the left coronary artery (segment 15). Co-dominance does not exist as an option at the SYNTAX score.

Total occlusion: TIMI 0 flow: no perfusion; no antegrade flow beyond the point of occlusion

Bridging collaterals: Small channels running in parallel to the vessel and connecting proximal vessel to distal and being responsible for the ipsilateral collateralization

Trifurcation: A junction of three branches, one main vessel and two side-branches. Trifurcations are only scored for the following segment junctions: 3/4/16/16a, 5/6/11/12, 11/12a/12b/13, 6/7/9/9a and 7/8/10/10a

Bifurcation: A junction of a main vessel and a side branch of at least 1.5mm in diameter. Bifurcations are only scored for the following segment junctions: 5/6/11, 6/7/9, 7/8/10, 11/13/12a, 13/14/14a, 3/4/16 and 13/14/15. Bifurcation lesions may involve one segment (types A, B and E), two segments (types C, F and G) or three segments (type D).

Aorto ostial: A lesion is classified as aorto-ostial when it is located immediately at the origin of the coronary vessels from the aorta (applies only to segments 1 and 5, or to 6 and 11 in case of double ostium of the LCA).

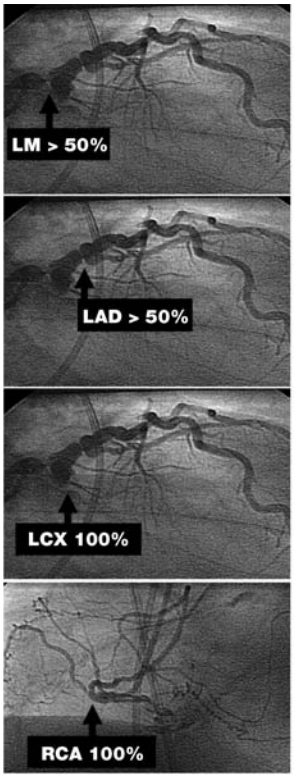
Severe tortuosity: One or more bends of 90° or more, or three or more bends of 45° to 90° proximal of the diseased segment.

Length >20mm: Estimation of the length of that portion of the stenosis that has ≥ 50% reduction in luminal diameter in the projection where the lesion appears to be the longest. (In case of a bifurcation lesion at least one of the branches has a lesion length of >20mm).

Heavy calcification: Multiple persisting opacifications of the coronary wall visible in more than one projection surrounding the complete lumen of the coronary artery at the site of the lesion.

Thrombus: Spheric, ovoid or irregular intraluminal filling defect or lucency surrounded on three sides by contrast medium seen just distal or within the coronary stenosis in multiple projections or a visible embolization of intraluminal material downstream.

Diffuse disease/small vessels: More than 75% of the length of the segment has a vessel diameter of 2mm, irrespective of the presence or absence of a lesion.



Lesion 1
Segment 5: 5x2 10
+ Bifurcation Type A 1
+ Heavy calcification 2
Lesion 1 score: 13

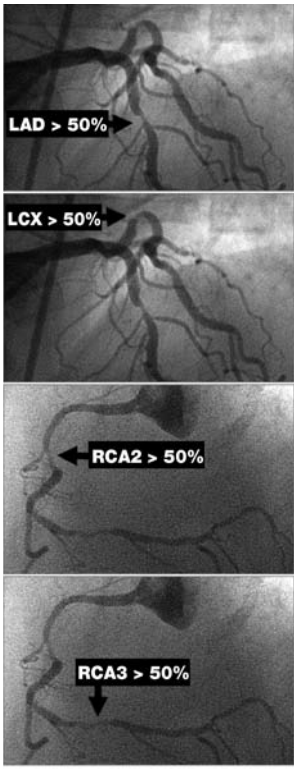
Lesion 2
Segment 6: 3,5x2 7
+ Bifurcation Type A 1
+ Angulation <70° 1
+ Heavy calcification 2
Lesion 2 score: 11

Lesion 3
Segment 11: 1,5x5 7,5
Age T.O. is unknown 1
+ Blunt stump 1
+ side branch 1
First segment visualized by contrast : 13 1
+ Heavy calcification 2
+ Lenght 1
Lesion 3 score: 14,5

Lesion 4
Segment 1: 1x5 5
Age T.O. is unknown 1
+ Blunt stump 1
+ side branch 1
first segment visualized by contrast: 4 3
+ Tortuosity 2
+ heavy calcification 2
+ Lenght 1
core: 16

SYNTAX SCORE 54.5

Figure 5.



Lesion 1
Segment 6: 3,5x2 7
Lesion 1 score: 7

Lesion 2
Segment 11: 1,5x2 3
+ Tortuosity 2
Lesion 2 score: 3

Lesion 3
Segment 1 : 1x2 2
Lesion 3 score: 2

Lesion 4
Segment 1: 1x2 2
+ tortuosity 2
+ Lenght 1
lesion 4 score: 5

SYNTAX SCORE 17

Figure 6.

coronary arteries with four lesions each but the calculated SYNTAX score differs greatly (54.5 versus 17) reflecting the more complex pattern of coronary artery disease in the patient with the higher score.

Validation

The utility of the SYNTAX score for predicting outcomes will be examined at three junctures in the conduct of the trial:

1. In phase I it will be evaluated based on patient allocation into the 3 study arms (randomized, PCI registry and CABG registry).
2. In phase II its utility at predicting early procedural outcomes (30 days) will be assessed and optimised.
3. In phase III it will be evaluated and the scoring will be optimized for predicting 1, 3 and 5 year outcomes.

Summary

The most important characteristic of the SYNTAX score to be emphasized is that it is focusing on anatomy of coronary vasculature and not on treatment plan.

The ultimate goal is to create an angiographic tool grading the complexity of coronary artery disease and obtain evidence based guidelines for selecting the optimal technique of revascularization (CABG or PCI). In addition it will allow comparison of coronary artery disease complexity in individual patients and entire patient cohorts, as well as assessment of adequacy and completeness of revascularisation.

In summary it's a score under investigation to predict prognosis based on disease complexity in coronary vasculature. It will be retroactively weighted based on clinical outcomes and potentially revised to optimize its prognostic value. Once validated and standardised the SYNTAX score will become available on-line.

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Percutaneous Coronary Intervention versus Coronary-Artery Bypass Grafting for Severe Coronary Artery Disease

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ABSTRACT

BACKGROUND

Percutaneous coronary intervention (PCI) involving drug-eluting stents is increasingly used to treat complex coronary artery disease, although coronary-artery bypass grafting (CABG) has been the treatment of choice historically. Our trial compared PCI and CABG for treating patients with previously untreated three-vessel or left main coronary artery disease (or both).

METHODS

We randomly assigned 1800 patients with three-vessel or left main coronary artery disease to undergo CABG or PCI (in a 1:1 ratio). For all these patients, the local cardiac surgeon and interventional cardiologist determined that equivalent anatomical revascularization could be achieved with either treatment. A noninferiority comparison of the two groups was performed for the primary end point — a major adverse cardiac or cerebrovascular event (i.e., death from any cause, stroke, myocardial infarction, or repeat revascularization) during the 12-month period after randomization. Patients for whom only one of the two treatment options would be beneficial, because of anatomical features or clinical conditions, were entered into a parallel, nested CABG or PCI registry.

RESULTS

Most of the preoperative characteristics were similar in the two groups. Rates of major adverse cardiac or cerebrovascular events at 12 months were significantly higher in the PCI group (17.8%, vs. 12.4% for CABG; P=0.002), in large part because of an increased rate of repeat revascularization (13.5% vs. 5.9%, P<0.001); as a result, the criterion for noninferiority was not met. At 12 months, the rates of death and myocardial infarction were similar between the two groups; stroke was significantly more likely to occur with CABG (2.2%, vs. 0.6% with PCI; P=0.003).

CONCLUSIONS

CABG remains the standard of care for patients with three-vessel or left main coronary artery disease, since the use of CABG, as compared with PCI, resulted in lower rates of the combined end point of major adverse cardiac or cerebrovascular events at 1 year. (ClinicalTrials.gov number, NCT00114972.)

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*The other Synergy between Percutaneous Coronary Intervention with Taxus and Cardiac Surgery (SYNTAX) investigators are listed in the Supplementary Appendix, available with the full text of this article at NEJM.org.

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Coronary-artery bypass grafting (CABG) was introduced in 1968 and rapidly became the standard of care for symptomatic patients with coronary artery disease.[1] Advances in coronary surgery (e.g., off-pump CABG, smaller incisions, enhanced myocardial preservation, use of arterial conduits, and improved postoperative care) have reduced morbidity, mortality, and rates of graft occlusion.[2-6]

Percutaneous coronary intervention (PCI) was introduced in 1977.[7] Experience with this approach, coupled with improved technology, has made it possible to treat increasingly complex lesions and patients with a history of clinically significant cardiac disease, risk factors for coronary artery disease, coexisting conditions, or anatomical risk factors.[8,9] Several trials comparing PCI involving bare-metal stents with CABG in patients with multivessel disease (e.g., the Arterial Revascularization Therapies Study Part I [ARTS I], the Medicine, Angioplasty, or Surgery Study for Multivessel Coronary Artery Disease [MASS II; Current Controlled Trials number, ISRCTN66068876], the Argentine Randomized Study of Coronary Angioplasty with Stenting versus Coronary Bypass Surgery in Patients with Multiple Vessel Disease [ERACI-II], and the Angina with Extremely Serious Operative Mortality Evaluation [AWESOME]) showed similar survival rates but higher revascularization rates among patients with bare-metal stents at 5 years. Others have shown a significant long-term survival advantage with surgery (e.g., the Stent or Surgery [SOS] study).[10-12] Studies comparing PCI involving drug-eluting stents with CABG have generally been smaller and nonrandomized.[13-24]

Data from randomized, controlled trials of drug-eluting stents as compared with bare-metal stents have shown significant reductions in the rate of repeat intervention, with similar rates of death and myocardial infarction.[25] These improvements have led to expanded use of PCI in patients with complex coronary anatomical features, though most randomized trials comparing drug-eluting stents and bare-metal stents excluded such patients. According to current guidelines,[26] CABG remains the treatment of choice for patients with severe coronary artery disease, including those with left main coronary artery disease and those with three-vessel disease. There is a lack of data from adequately powered randomized trials of PCI in such patients. Thus, PCI is being performed in this group without adequate support from evidence-based medicine and randomized clinical trials.[27]

In the Synergy between PCI with Taxus and Cardiac Surgery (SYNTAX) trial, we assessed the optimal revascularization strategy for patients with previously untreated three-vessel or left main coronary artery disease and defined the populations of patients for whom only one revascularization method will be effective.

METHODS

STUDY DESIGN

The SYNTAX trial is a prospective, clinical trial conducted in 85 sites and approved by the institutional review board at each participating center. The study had an "all-comers" design involving the consecutive enrollment of all eligible patients with three-vessel or left main coronary artery disease at sites in 17 countries in Europe and the United States. The study design has been described previously.[28] Criteria for study and registry enrollment and outcome data are described in the Supplementary Appendix. The authors designed the study, as part of their role on the steering committee, in collaboration with the sponsor, Boston Scientific. The sponsor was involved in collection and source verification of the data, with oversight by an independent clinical events committee. The sponsor's biostatisticians performed the analyses; however, data analyses were verified independently by a statistician on the data and safety monitoring committee. The authors wrote the manuscript and vouch for the completeness and accuracy of the data gathering and analysis.

SELECTION AND RANDOMIZATION OF PATIENTS

A local interventional cardiologist and cardiac surgeon at each site prospectively evaluated eligible patients with previously untreated three-vessel coronary disease and those with left main coronary artery disease (alone or with one-, two-, or three-vessel disease). Inclusion and exclusion criteria are listed in the Methods section of the Supplementary Appendix. Patients in whom it was determined that equivalent anatomical revascularization could be achieved with either CABG or PCI involving Taxus Express paclitaxel-eluting stents (Boston Scientific) were randomly assigned to undergo one of the two treatment options by means of an interactive voice-responding system. Ran-

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domization was stratified at each site according to the presence or absence of left main coronary artery disease and medically treated diabetes (diabetes for which the patient was receiving oral hypoglycemic agents or insulin at the time of enrollment). Patients for whom only one treatment option was suitable were entered into a parallel, nested registry: the PCI registry for CABG-ineligible patients and the CABG registry for PCI-ineligible patients.

All diagnostic angiograms and electrocardiograms were reviewed by staff at an independent core laboratory (Cardialysis, Rotterdam, the Netherlands) who were unaware of the treatment assignments. Diagnostic angiograms were scored, according to the SYNTAX score algorithm,[29] at the site and at the core laboratory. In addition, staff at an independent central chemistry laboratory (Covance, Indianapolis and Geneva) who were unaware of treatment assignments assessed selected variables.

The institutional review board at each site approved the protocol, and all patients provided written informed consent. The protocol and consent forms were consistent with the Food and Drug Administration's Guidance for Industry E6 Good Clinical Practice, the Declaration of Helsinki, the International Conference on Harmonisation, and all local regulations, as appropriate.

REVASCULARIZATION AND PHARMACOLOGIC TREATMENT

Patients were treated with the intention of achieving complete revascularization of all vessels at least 1.5 mm in diameter with stenosis of 50% or more, as identified by the local interventional cardiologist and cardiac surgeon. The surgical technique for CABG, the approaches used for stent implantation, and the postprocedure medication regimen were chosen according to local clinical practice. In patients who underwent PCI, antiplatelet medication was prescribed on the basis of the directions for use of the Taxus Express stent and local clinical practice. In most centers, thienopyridines were continued even after 6 months, with 71.1% of patients receiving them at 12 months. Aspirin was prescribed indefinitely for all patients who underwent randomization. Use of the standard of postintervention care was recommended.[30] Procedural details are described in the Methods section of the Supplementary Appendix.

PRIMARY END POINT

The primary clinical end point was a composite of major adverse cardiac and cerebrovascular events (i.e., death from any cause, stroke, myocardial infarction, or repeat revascularization) throughout the 12-month period after randomization. An independent clinical events committee (including cardiologists, cardiac surgeons, and a neurologist; see the list in the Supplementary Appendix) adjudicated all primary clinical end points, staged procedures, and cases in which the sternum was reopened.

STATISTICAL ANALYSIS

The primary analysis was a noninferiority comparison of the two treatments for the primary end point of adverse binary cardiac or cerebrovascular events in all patients who underwent randomization (on an intention-to-treat basis). If the one-sided 95% upper confidence limit for the difference was less than the prespecified delta value (6.6%), PCI with the drug-eluting stents would be considered to be noninferior to CABG in the overall randomized cohort. The noninferiority margin was based on historical data (see the Methods section in the Supplementary Appendix). We calculated the means (±SD) for continuous variables in each of the two groups and compared them using Student's t-test. Binary variables are reported as counts and percentages, and differences between the two groups were assessed by means of the chi-square or Fisher's exact test. Cumulative event rates were estimated by means of the Kaplan–Meier method. In addition, the 12-month rates of major adverse cardiac or cerebrovascular events were analyzed on the basis of the SYNTAX score and compared with the use of a chi-square test. The SYNTAX score reflects a comprehensive anatomical assessment, with higher scores indicating more complex coronary disease; a low score was defined as ≤22, an intermediate score as 23 to 32, and a high score as ≥33 (see the Supplementary Appendix for details).

RESULTS

STUDY PARTICIPANTS

From March 2005 through April 2007, a total of 4337 patients with previously untreated three-vessel or left main coronary artery disease (or both) were screened (Fig. 1). After consideration by the local

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interventional cardiologist and cardiac surgeon and after written informed consent was obtained, 3075 patients (70.9%) were included in the study. Of these, 1800 patients were randomly assigned to undergo CABG (897 patients) or PCI with drug-eluting stents (903 patients) at sites in the United States (245 patients) and in Europe (1555 patients). The reasons for exclusion of the remaining 1262 patients are listed in Figure 1. Only one treatment option was suitable in 1275 patients (29.4%), who were enrolled in the nested registry for CABG (1077 patients) or PCI (198 patients).

Patients in the two groups were well balanced with regard to most of the baseline demographic and clinical characteristics (Table 1). The proportion of patients with blood pressure of 130/80 mm Hg or higher was significantly larger in the PCI group. The numbers of current smokers, patients with elevated triglyceride levels (≥150 mg per deciliter [1.7 mmol per liter]), and patients with reduced high-density lipoprotein cholesterol levels (<40 mg per deciliter [1.0 mmol per liter] for men or <50 mg per deciliter [1.3 mmol per liter] for women) were higher in the CABG group. A total of 38.8% of patients in the CABG group and 39.5% of those in the PCI group had left main coronary artery disease, with or without additional diseased vessels. Approximately 25% of patients had medically treated diabetes, of whom about one third required insulin. Moreover, nearly half the patients (45.8%) met the criteria for the metabolic syndrome.[33] More than 20% of patients in both groups were considered to be at high surgical risk, on the basis of a European System for Cardiac Operative Risk Evaluation (euroSCORE)[31] value of 6 or more (24.9% in the CABG group and 24.7% in the PCI group, P=0.94) and a Parsonnet score[32] of 15 or more (20.2% and 20.5%, respectively; P=0.87).

Overall, more than 4 clinically significant coronary lesions were treated per patient (mean, 4.4 for CABG and 4.3 for PCI); among all patients in both groups, total occlusion was identified in 23.1%, and 72.8% had a bifurcation lesion (Table 1). These results, together with other lesion characteristics, resulted in an average raw SYNTAX score of 29.1 in the CABG group and 28.4 in the PCI group (P=0.19) (Table 1).

The length of time between randomization and performance of the study procedure, the duration of the procedure, and the duration of the post-procedural hospital stay were significantly greater with CABG than with PCI (Table 1). A higher proportion of patients had complete revascularization after CABG than after PCI (63.2% vs. 56.7%, P=0.005). Medical management at discharge differed between the CABG and PCI groups: patients who underwent CABG received less pharmacologic treatment, whereas those who underwent PCI were consistently treated with antiplatelet medications (Table 2). In the CABG group, off-pump surgery was performed in 15.0% of patients, one or more arterial grafts were used in 97.3% of patients, and an average of 2.8 conduits and 3.2 distal anastomoses per patient were performed. In the PCI group, 14.1% of patients underwent staged procedures, 63.1% had at least one bifurcation or trifurcation treated, more than four stents on average were implanted per patient, and a third of patients had placement of stents with a total length of more than 100 mm.

A greater proportion of patients in the CABG registry had characteristics of severe lesions — including large proportions of patients with total occlusion (56.4%), bifurcation (80.8%), lesions that were more than 20 mm in length (31.5%), and heavy calcification (32.7%) — than in either randomized group or the PCI registry (Table 2 in the Supplementary Appendix). Together with other anatomical characteristics, these features resulted in an average raw SYNTAX score of 37.8±13.3 among the patients in the CABG registry (Table 2 in the Supplementary Appendix). In contrast, the prevalence of cardiac risk factors and the prevalence of coexisting conditions were increased among patients enrolled in the PCI registry. A total of 30.2% of these patients had diabetes, 40.4% had previously had a myocardial infarction, 19.3% had a diagnosis of chronic obstructive pulmonary disease, 14.1% had a history of transient ischemic attacks or stroke, and 4.7% were dependent on pacemakers — leading to average surgical scores that were higher than in the other groups of patients (euroSCORE value, 5.8±3.1; and Parsonnet score, 14.4±9.5) (Table 2 in the Supplementary Appendix).

PRIMARY OUTCOME

Preprocedural rates of major adverse cardiac or cerebrovascular events were low and did not differ significantly between the two groups (0.9% in the CABG group and 0.3% in the PCI group, P=0.13) (Table 6 in the Supplementary Appendix), as was the case for in-hospital rates. The preprocedural

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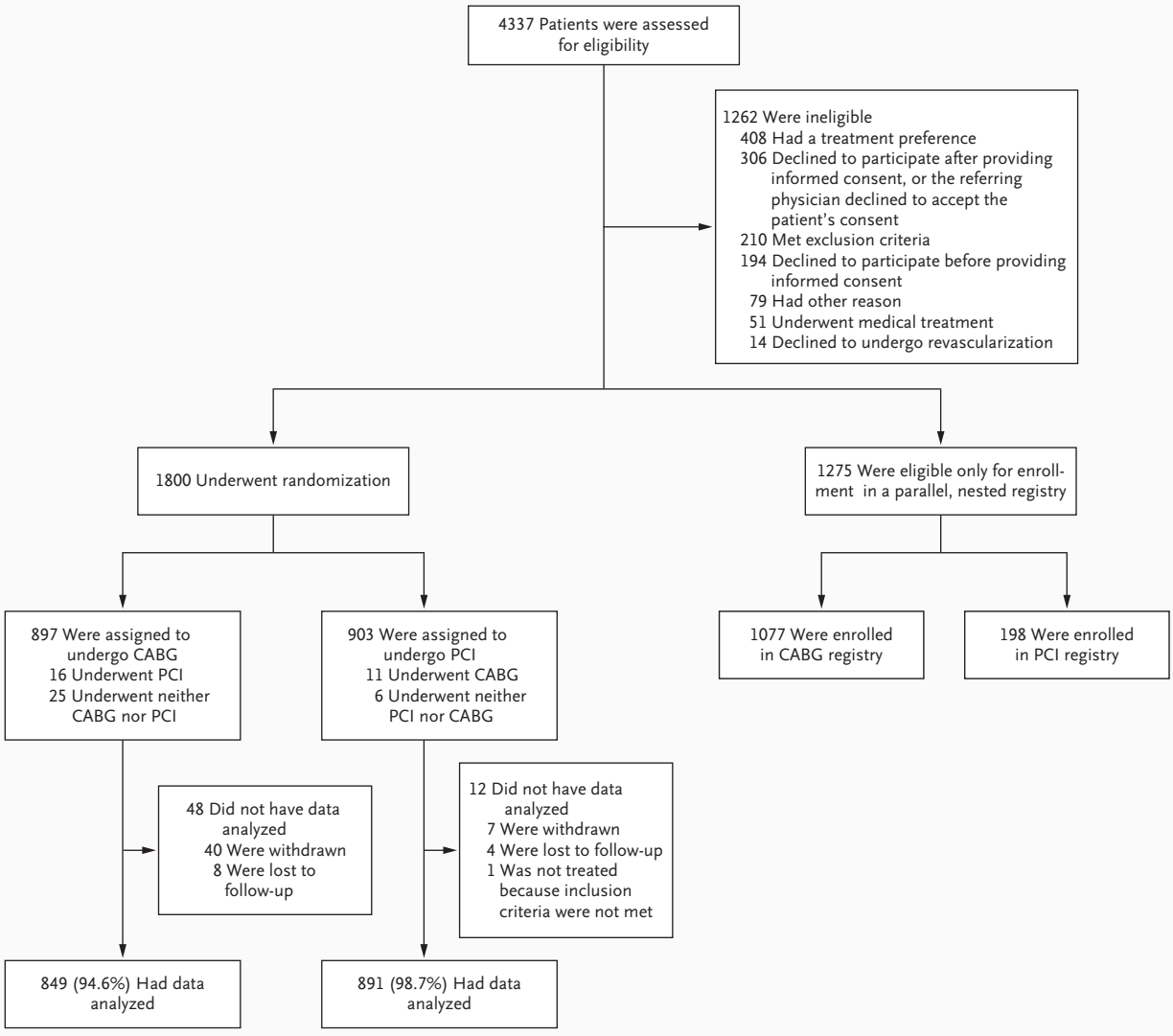

Figure 1. Enrollment and Randomization of Patients with Previously Untreated Three-Vessel or Left Main Coronary Artery Disease in the SYNTAX Trial.

The trial used an "all-comers" design. Exclusion criteria were previous intervention, acute myocardial infarction, and concomitant surgery. Patients meeting either of the first two exclusion criteria were, according to the trial design, excluded without consultation of the local interventional cardiologist and cardiac surgeon. The need for concomitant surgery was discussed with the local interventional cardiologist and cardiac surgeon. Data for patients who were assigned to one treatment but underwent the other and for those who did not undergo either revascularization procedure were analyzed in an intention-to-treat manner. CABG denotes coronary-artery bypass grafting, and PCI percutaneous coronary intervention.

rates of two of the individual components of the primary outcome, stroke and myocardial infarction, were similar in the two groups (Table 2 in the Supplementary Appendix). At 12 months, the incidence of major adverse cardiac or cerebrovascular events was lower in the CABG group (12.4%) than in the PCI group (17.8%, P=0.002) (Fig. 2 and Table 3). Thus, the absolute difference in the 12-month rate of major adverse cardiac or cerebrovascular events between the two groups was 5.5 percentage points, with an upper 95% confidence interval of 8.3 percentage points. The results of an as-treated analysis were similar: the 12-month rate of major adverse cardiac or cerebrovascular events was 12.3% with CABG and 17.6% with PCI (P=0.002).

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Table 1. Baseline Characteristics of the Patients, According to Study Group.*

Characteristic	PCI (N=903)	CABG (N=897)	P Value
Age — yr	65.2±9.7	65.0±9.8	0.55
Male sex — %	76.4	78.9	0.20
Body-mass index†	28.1±4.8	27.9±4.5	0.37
Medically treated diabetes — %‡			
Any	25.6	24.6	0.64
Requiring insulin	9.9	10.4	0.72
Metabolic syndrome — %	46.0	45.5	0.86
Current smoker — %	18.5	22.0	0.06
Previous myocardial infarction — %	31.9	33.8	0.39
Previous stroke — %	3.9	4.8	0.33
Previous transient ischemic attack — %	4.3	5.1	0.46
Blood pressure ≥130/85 mm Hg — %	68.9	64.0	0.03
Congestive heart failure — %	4.0	5.3	0.18
Carotid artery disease — %	8.1	8.4	0.83
Hyperlipidemia — %	78.7	77.2	0.44
Triglycerides ≥150 mg/dl (1.7 mmol/liter) — %	32.3	38.7	0.007
HDL cholesterol <40 mg/dl (1.0 mmol/liter) for men or <50 mg/dl (1.3 mmol/liter) for women — %	46.2	52.5	0.01
Angina — %			
Stable	56.9	57.2	0.91
Unstable	28.9	28.0	0.66
Ejection fraction <30% — %	1.3	2.5	0.08
euroSCORE value	3.8±2.6	3.8±2.7	0.78
Parsonnet score	8.5±7.0	8.4±6.8	0.76
SYNTAX score	28.4±11.5	29.1±11.4	0.19
No. of lesions	4.3±1.8	4.4±1.8	0.44
Total occlusion — %	24.2	22.2	0.33
Bifurcation — %	72.4	73.3	0.67
Time to procedure — days	6.9±13.0	17.4±28.0	<0.001
Procedure duration — hr	1.7±0.9	3.4±1.1	<0.001
Postprocedural hospital stay — days	3.4±4.5	9.5±8.0	<0.001
Complete revascularization — %	56.7	63.2	0.005

* Plus–minus values are means ±SD. Data are given for the intention-to-treat population. P values, the average SYNTAX score, the average number of lesions, and the percentages of patients with total occlusion and bifurcation were calculated at the core laboratory. The European System for Cardiac Operative Risk Evaluation (euroSCORE) value could range from 0 to 18, with increasing values reflecting a higher predicted operative mortality.[31] The Parsonnet score could range from 0 to 47, with increasing values reflecting a higher predicted in-hospital mortality.[32] The SYNTAX score reflects a comprehensive anatomical assessment, with scores ranging from 0 to 83 and higher scores indicating more complex coronary disease (see the Supplementary Appendix for details). CABG denotes coronary-artery bypass grafting, HDL high-density lipoprotein, and PCI percutaneous coronary intervention.

† The body-mass index is the weight in kilograms divided by the square of the height in meters.

‡ Medically treated diabetes was defined as diabetes for which the patient was receiving oral hypoglycemic agents or insulin at the time of enrollment.

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In the intention-to-treat population, 19 patients would need to be treated with CABG to avoid the primary outcome in 1 patient; the numbers needed to treat to avoid specific components of the outcome were 14 for revascularization, 119 for death, and 71 for myocardial infarction. The number needed to treat with PCI to avoid stroke in 1 patient was 60.

SECONDARY OUTCOME

The rate of repeat revascularization at 12 months was significantly higher among patients in the PCI group than among those in the CABG group (13.5% vs. 5.9%, P<0.001) (Table 3). Most patients who underwent repeat revascularization were treated with PCI rather than CABG. The rate of stroke was significantly higher with CABG than with PCI at 12 months, even though the two groups were well balanced with regard to carotid artery disease and other risk factors for stroke (Table 3). At 12 months, the two groups had similar rates of death from any cause or myocardial infarction and of the combined end point of death from any cause, stroke, or myocardial infarction (Table 3). The rate of death from cardiac causes was greater with PCI than with CABG (3.7% vs. 2.1%, P=0.05); the rate of death from noncardiac causes, although not significant, was higher with CABG (1.4% vs. 0.7%, P=0.13). The 12-month rates of symptomatic graft occlusion (in the CABG group) and stent thrombosis (in the PCI group) were similar (P=0.89) (Table 3).

OUTCOMES ACCORDING TO THE SYNTAX SCORE

In the CABG group, the binary 12-month rates of major adverse cardiac or cerebrovascular events were similar among patients with low SYNTAX scores (0 to 22, 14.7%), those with intermediate scores (23 to 32, 12.0%), and those with high scores (≥33, 10.9%) (Fig. 3). In contrast, in the PCI group, the rate of major adverse cardiac or cerebrovascular events was significantly increased among patients with high SYNTAX scores (23.4%) as compared with those with low scores (13.6%) or intermediate scores (16.7%) (P=0.002 for high vs. low scores; P=0.04 for high vs. intermediate scores) (Fig. 3). There was a significant interaction between SYNTAX score and treatment group (P=0.01); patients with low or intermediate scores in the CABG group and in the PCI group had similar rates of major adverse cardiac or cerebrovascular events, whereas among patients with high scores, the event rate was significantly increased in the PCI group (Fig. 3).

Table 2. Cardiac-Related Medications Given after the Study Procedure.*

Medication	PCI	CABG	P Value
	percent		
Any	98.9	98.6	0.62
Aspirin			
At discharge	96.3	88.5	<0.001
1 Mo after procedure	93.5	85.4	<0.001
6 Mo after randomization	93.2	82.7	<0.001
12 Mo after randomization	91.2	84.3	<0.001
Thienopyridine			
At discharge	96.8	19.5	<0.001
1 Mo after procedure	95.5	18.4	<0.001
6 Mo after randomization	91.3	16.1	<0.001
12 Mo after randomization	71.1	15.0	<0.001
Any antiplatelet drug			
At discharge	97.0	23.7	<0.001
1 Mo after procedure	95.8	21.2	<0.001
6 Mo after randomization	91.4	18.4	<0.001
12 Mo after randomization	72.8	17.2	<0.001
Nonthienopyridine antiplatelet drug	1.9	4.8	<0.001
Warfarin derivative	2.6	7.1	<0.001
Statin	86.7	74.5	<0.001
Beta-blocker	81.3	78.6	0.17
ACE inhibitor	55.1	44.6	<0.001
Calcium-channel blocker	25.8	18.4	<0.001
Angiotensin II–receptor antagonist	13.3	7.0	<0.001
Amiodarone	1.5	12.8	<0.001
H_2-receptor blocker	14.5	21.7	<0.001

* Percentages are from the intention-to-treat analysis. ACE denotes angiotensin-converting enzyme, CABG coronary-artery bypass grafting, and PCI percutaneous coronary intervention.

OUTCOMES IN SUBGROUPS

The subgroups of patients with left main or three-vessel coronary artery disease were prespecified, and the study had a statistical power of 80% for each subgroup. However, the overarching statistical test was a noninferiority assessment of data from all patients with either left main coronary artery disease or three-vessel coronary disease (or both). Since noninferiority was not proven in this

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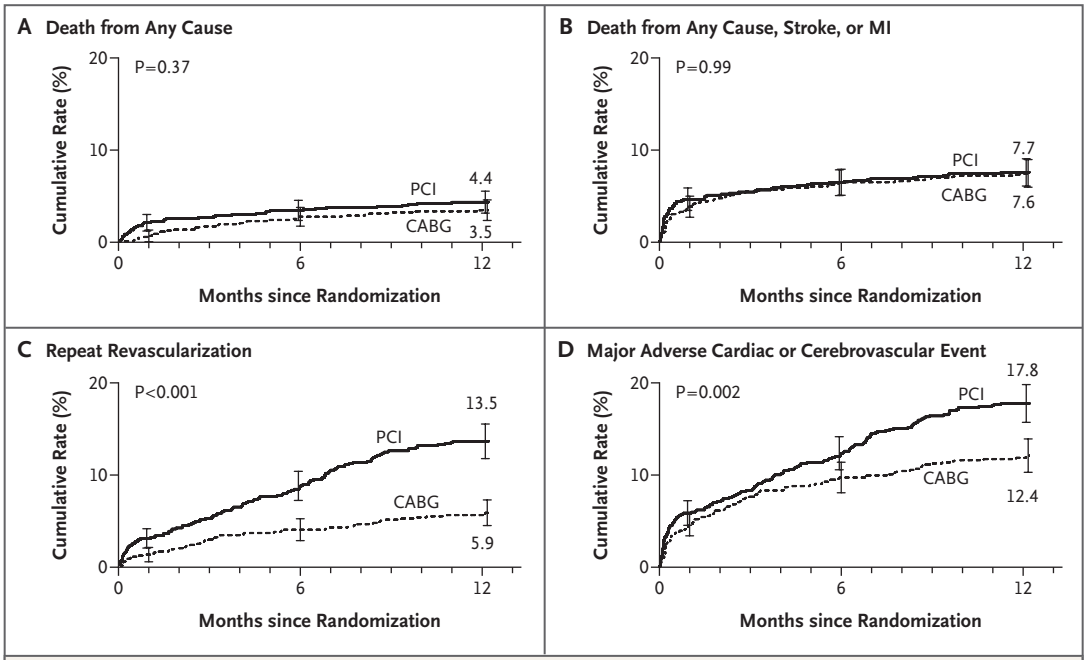

Figure 2. Rates of Outcomes among the Study Patients, According to Treatment Group.

Kaplan–Meier curves are shown for the percutaneous coronary intervention (PCI) group and the coronary-artery bypass grafting (CABG) group for death from any cause (Panel A); death, stroke, or myocardial infarction (MI) (Panel B); repeat revascularization (Panel C); and the composite primary end point of major adverse cardiac or cerebrovascular events (Panel D). The two groups had similar rates of death from any cause (relative risk with PCI vs. CABG, 1.24; 95% confidence interval [CI], 0.78 to 1.98) and rates of death from any cause, stroke, or MI (relative risk with PCI vs. CABG, 1.00; 95% CI, 0.72 to 1.38). In contrast, the rate of repeat revascularization was significantly increased with PCI (relative risk, 2.29; 95% CI, 1.67 to 3.14), as was the overall rate of major adverse cardiac or cerebrovascular events (relative risk, 1.44; 95% CI, 1.15 to 1.81). The I bars indicate 1.5 SE. Relative risks were calculated from the binary rates. P values were calculated with the use of the chi-square test.

cohort, specific information for each subgroup is of an observational nature and is hypothesis generating. The 12-month rate of major adverse cardiac or cerebrovascular events among patients with left main coronary artery disease was similar in the CABG and PCI groups (13.7% and 15.8%, respectively; P=0.44). Although the rate of repeat revascularization among patients with left main coronary artery disease was significantly higher in the PCI group (11.8%, vs. 6.5% in the CABG group; P=0.02), this result was offset by a significantly higher rate of stroke in the CABG subgroup of patients with left main coronary artery disease (2.7%, vs. 0.3% in the corresponding PCI subgroup; P=0.01). A total of 36.6% of patients with left main coronary artery disease also had three-vessel disease. A post hoc analysis of the rates of major adverse cardiac or cerebrovascular events in the subgroups of patients with left main coronary artery disease revealed a higher rate among those who also had two- or three-vessel disease than among those with left main coronary artery disease alone or in combination with one-vessel disease (Fig. 6 in the Supplementary Appendix).

The 12-month rate of major adverse cardiac or cerebrovascular events among patients with three-vessel disease in the absence of left main coronary artery disease was significantly increased in the PCI group as compared with the CABG group (19.2% vs. 11.5%, P<0.001) (Fig. 6 in the Supplementary Appendix), as was the rate of repeat revascularization (14.6% vs. 5.5%, P<0.001). The rate of death from any cause, stroke, or myocardial infarction in this subgroup was similar with PCI and CABG (8.0% and 6.6%, respectively; P=0.39).

Comparisons of data for the cohort with left main coronary artery disease and the cohort with three-vessel disease showed that the cohort with three-vessel disease had higher rates of previous

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Table 3. Clinical End Points Occurring in the Hospital or after Discharge, According to Study Group.*

Variable	PCI	CABG	P Value	Relative Risk with PCI (95% CI)
	no./total no. (%)			
Major adverse cardiac or cerebrovascular event				
In hospital	39/896 (4.4)	47/870 (5.4)	0.31	0.81 (0.53–1.22)
30 Days after procedure	54/895 (6.0)	45/866 (5.2)	0.45	1.16 (0.79–1.71)
6 Mo after randomization	111/893 (12.4)	85/860 (9.9)	0.09	1.26 (0.96–1.64)
12 Mo after randomization	159/891 (17.8)	105/849 (12.4)	0.002	1.44 (1.15–1.81)
Death, stroke, or MI	68/891 (7.6)	65/849 (7.7)	0.98	1.00 (0.72–1.38)
Death	39/891 (4.4)	30/849 (3.5)	0.37	1.24 (0.78–1.98)
From cardiac causes	33/891 (3.7)	18/849 (2.1)	0.05	1.75 (0.99–3.08)
From cardiovascular causes	1/891 (0.1)	3/849 (0.4)	0.36†	0.32 (0.03–3.05)
From noncardiovascular causes	5/891 (0.6)	9/849 (1.1)	0.24	0.53 (0.18–1.57)
Stroke	5/891 (0.6)	19/849 (2.2)	0.003	0.25 (0.09–0.67)
MI	43/891 (4.8)	28/849 (3.3)	0.11	1.46 (0.92–2.33)
Repeat revascularization‡	120/891 (13.5)	50/849 (5.9)	<0.001	2.29 (1.67–3.14)
CABG	25/891 (2.8)	11/849 (1.3)	0.03	2.17 (1.07–4.37)
PCI	102/891 (11.4)	40/849 (4.7)	<0.001	2.43 (1.71–3.46)
Graft occlusion or stent thrombosis§	28/848 (3.3)	27/784 (3.4)	0.89	0.96 (0.57–1.62)
Acute (at ≤1 day)	2/896 (0.2)	3/870 (0.3)	0.68†	0.65 (0.11–3.86)
Early (within 2–30 days)	18/893 (2.0)	3/868 (0.3)	0.001	5.83 (1.72–19.73)
Late (within 31–365 days)	9/874 (1.0)	21/854 (2.5)	0.02	0.42 (0.19–0.91)

* Percentages are from the intention-to-treat analysis. P values were calculated with the use of the chi-square test, unless otherwise noted. CABG denotes coronary-artery bypass grafting, MI myocardial infarction, and PCI percutaneous coronary intervention.
† The P value was calculated with the use of Fisher's exact test.
‡ One patient randomly assigned to undergo CABG and seven patients randomly assigned to undergo PCI underwent both repeat PCI and repeat CABG.
§ Stent thrombosis was adjudicated according to the protocol definition.

myocardial infarction, diabetes, poor left ventricular ejection fraction, and lesions with adverse characteristics (lesions that were totally occluded, bifurcated, or long). In addition, the cohort with three-vessel disease had increased numbers of treated vessels and lesions per patient.

DISCUSSION

The SYNTAX trial was designed to compare current surgical and percutaneous techniques in patients with three-vessel or left main coronary artery disease (or both). For the primary end point, the 12-month rate of major adverse cardiac or cerebrovascular events, the noninferiority of PCI as compared with CABG was not demonstrated; CABG proved to be superior. Therefore, the findings with regard to components of the primary end point and subgroup analyses can only be considered as hypothesis-generating. Rates of death and myocardial infarction at 1 year were similar between patients who underwent CABG and those who underwent PCI with drug-eluting stents, whereas the rate of stroke was increased in the CABG group and the rate of repeat revascularization was increased in the PCI group.

Rates of repeat revascularization at 12 months were low in the PCI group, given the high rates of several known predictors of restenosis: lesions characterized by bifurcation or trifurcation (>80%), multivessel disease (>60%), diabetes (>25%), and lesions that were long (>20 mm in length, 20%) or totally occluded (>25%). This rate of repeat revascularization is lower than the rates reported

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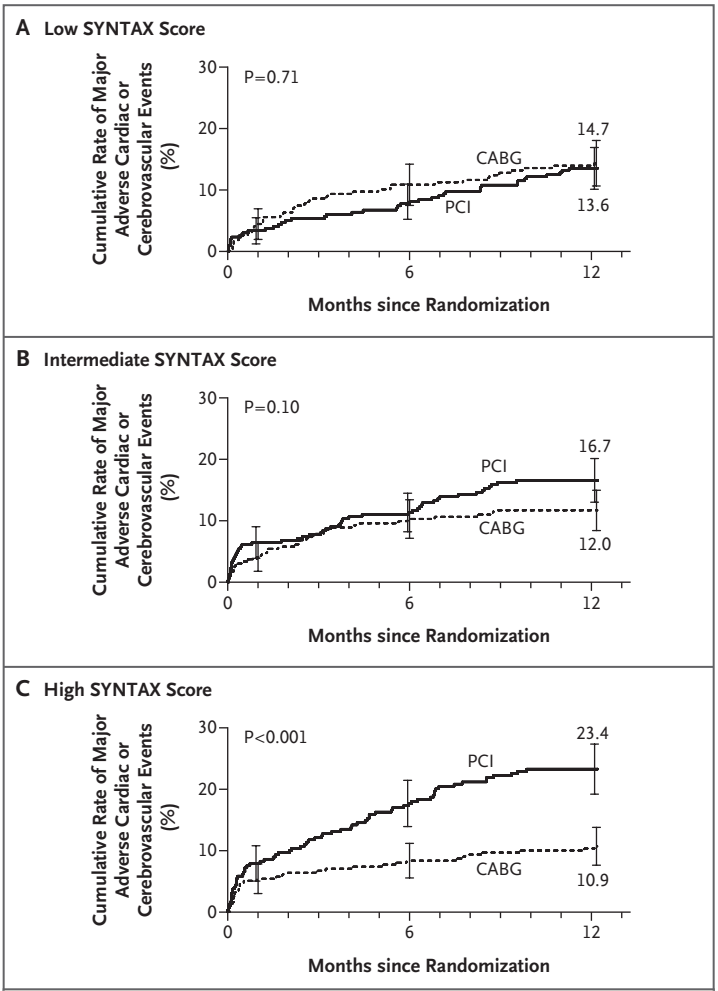

Figure 3. Rates of Major Adverse Cardiac or Cerebrovascular Events among the Study Patients, According to Treatment Group and SYNTAX Score Category.

Kaplan–Meier curves are shown for the percutaneous coronary intervention (PCI) group and the coronary-artery bypass grafting (CABG) group for major adverse cardiac or cerebrovascular events at 12 months. The 12-month event rates were similar between the two treatment groups for patients with low SYNTAX scores (0 to 22) (Panel A) or intermediate SYNTAX scores (23 to 32) (Panel B). Among patients with high SYNTAX scores (≥33, indicating the most complex disease), those in the PCI group had a significantly higher event rate at 12 months than those in the CABG group. SYNTAX scores were calculated at the core laboratory. The I bars indicate 1.5 SE. P values were calculated with the use of the chi-square test.

in previous comparative trials involving patients with less-complex clinical profiles and lesions.[10] The increase in the rate of repeat revascularization with PCI as compared with CABG did not appear to translate into a significant overall increase in the rate of death or myocardial infarction, although longer-term follow-up is needed. The risk of repeat revascularization after PCI needs to be balanced against the invasiveness of CABG and the risk of stroke, as previously reported in a meta-analysis of 23 studies comparing CABG and PCI, in which procedure-related strokes were found to be more common after CABG (in 1.2% of patients, vs. 0.6% of those undergoing PCI; P<0.001), without a concomitant decrease in survival.[34]

Recently, concern has been expressed about the possibility of an increased risk of late stent thrombosis with drug-eluting stents. In the SYNTAX trial, most cases of stent thrombosis occurred within 30 days after the procedure, and the 12-month rate of stent thrombosis in the PCI group was similar to the rate of symptomatic graft occlusion in the CABG group. However, as described in the literature, stent thrombosis often has more serious consequences for patients (rate of death, approximately 30%; rate of myocardial infarction, >60%)[35,36] than does graft occlusion, which often results only in angina leading to revascularization.

The use of antiplatelet medication was high among patients in the PCI group (with 71.1% receiving a thienopyridine at 12 months). There was an imbalance between the two groups with regard to general medical management apart from thienopyridine use. Thienopyridine therapy was not mandated beyond 6 months in the PCI group, since the study was designed to compare current CABG and PCI practices, including medication regimens. The low rate of stroke among patients who underwent PCI may have resulted from the use of highly effective dual-antiplatelet therapy, which prevents thromboembolic events; additional treatment with antiplatelet drugs might therefore benefit patients undergoing CABG. In addition, more patients in the CABG group than in the PCI group declined to participate after providing consent; in general, this imbalance was due to the greater invasiveness of CABG.

The SYNTAX score was designed to predict outcomes related to anatomical characteristics and, to a lesser extent, the functional risk of occlusion for any segment of the coronary-artery bed (as reflected by the Leaman score[37]). In our study, the raw SYNTAX score was predictive of outcomes in patients who underwent PCI. In particular, among patients in the PCI group with high SYNTAX scores, not only was the overall rate of major adverse cardiac or cerebrovascular events significantly increased, but also the rate of the composite components of death, stroke, and myocardial

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infarction was slightly raised (11.9%, vs. 7.6% in the CABG group; P=0.08). This finding suggests that a percutaneous approach should be avoided in patients with high SYNTAX scores. Similar results were reported after the stratification of patients with three-vessel disease in the ARTS II registry.[38] Retrospective analysis of the ability of the SYNTAX score to predict outcome is currently being performed and is anticipated to be used to evaluate the relative weight of the individual score components. Additional validation of the score in other populations of patients is also needed. Outcomes in the surgical group of our randomized cohort were not influenced by the SYNTAX score.

The completeness of revascularization (i.e., whether all identified lesions were treated) was determined after the procedure by the investigator. The rate of complete revascularization was lower in both treatment groups in our study than in previous studies.[14,15,21,23,39] This result is most likely due to a different definition of completeness of treatment used in the earlier trials and the more complex anatomical characteristics of the patients in our trial.

Although our study provides important information about current treatment of coronary artery disease, there are limitations. First, the 12-month follow-up period may not be sufficient to reflect the true long-term effect of CABG as compared with PCI with drug-eluting stents on cardiac-related health. However, our early results in terms of major adverse cardiac or cerebrovascular events are similar to those of a meta-analysis[34] of trials comparing CABG and PCI with predominantly bare-metal stents. The meta-analysis showed that the rate of major adverse cardiac or cerebrovascular events was lower with CABG than with PCI and that patients who underwent CABG had fewer repeat revascularization procedures than patients who underwent PCI. After 5 years of follow-up, the meta-analysis did not show any significant differences in rates of survival between the CABG and PCI groups,[34] although other studies have shown differences in mortality.[10-12]

Second, the use of medication differed between the groups in our study, reflecting variations in standard care of patients between the two treatment groups. Third, more patients withdrew, after randomization, from the CABG group than from the PCI group. Fourth, although randomization was conducted in a blinded manner, with clinicians and participants unaware of future treatment assignments, it was not possible to blind the performance of the treatment. Finally, the definition of myocardial infarction was based on a surgical definition (the finding of a new Q-wave on electrocardiography, in association with a value for the creatine kinase MB fraction that was five times the upper limit of the normal range), which may have resulted in less severe cases of myocardial infarction being overlooked.

In conclusion, the results of our trial show that CABG, as compared with PCI, is associated with a lower rate of major adverse cardiac or cerebrovascular events at 1 year among patients with three-vessel or left main coronary artery disease (or both) and should therefore remain the standard of care for such patients.



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AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes Screen

April 2012

Repair of Arterial and Venous Blockage

In September 2011, CPT Codes 35475 *Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel* and 35476 *Transluminal balloon angioplasty, percutaneous; venous* were identified in the CMS High Expenditure Procedure Codes screen.

35475
The RUC reviewed survey results of 84 diagnostic and interventional radiologists and interventional nephrologists and determined that physician work values were overestimated at the 25th percentile, 7.00 work RVUs. The RUC confirmed that 35475 is also reported with 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report* (work RVU=3.72) and 75962 *Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation* (work RVU=0.54) and that the Multiple Procedure Payment Reduction rule is applied to 36147 when performed with another service. Therefore, there is no duplication of physician work when these services are performed on the same day. To obtain an accurate value for this service, the RUC reviewed CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty (work RVU=9.00)* and determined that by removing 1.86 work RVUs to account for the multiple procedure reduction and 0.54 work RVUs accounting for the radiologic supervision and interpretation included in code 37224, the resulting value would be 6.60 work RVUs. The RUC agreed that this value accurately describes the physician work inherent in code 35475. To justify a work RVU of 6.60 for this service, the RUC reviewed CPT code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU=6.74, pre-75, intra-45, post-30) and determined that these services required similar physician work, time and intensity components. **The RUC recommends a work RVU of 6.60 for CPT Code 35475.**

35476
The RUC reviewed the survey results from 85 diagnostic and interventional radiologists and interventional nephrologists and determined that the 25th percentile work RVU of 5.10 appropriately accounts for the physician work required to perform this service. This code is also reported with 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report* (work RVU=3.72) and 75962 *Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation* (work RVU=0.54). The RUC noted that the Multiple Procedure Payment Reduction rule is applied to 36147 when performed with another service. Therefore, there is no duplication of physician work when these services are performed on the same day. The RUC compared 35476 to CPT code

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37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and determined that removing 1.86 to account for the multiple procedure payment rule and 0.54 for supervision and interpretation would appropriately derive a comparable work RVU of 5.75 to the recommended value for 35476. The RUC also reviewed CPT Code 52276 *Cystourethroscopy with direct vision internal urethrotomy* (work RVU=4.99) and agreed that with identical intra-service time of 35 minutes these services should be valued similarly. **The RUC recommends a work RVU of 5.10 for CPT code 35476.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommenda-tion
⊙35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	000	6.60
⊙35476	Transluminal balloon angioplasty, percutaneous; venous (For radiological supervision and interpretation, use 75978)	000	5.10

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:35475 Tracking Number Original Specialty Recommended RVU: **7.00**
Presented Recommended RVU: **7.00**
Global Period: 000 RUC Recommended RVU: **6.60**

CPT Descriptor: Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old woman with chronic kidney disease has an upper extremity AV hemodialysis access, with signs and symptoms of inflow stenosis. The AV shunt is accessed (separately reported) and arteriography of the inflow vessels performed (separately reported) revealing a stenosis central to the arterial anastomosis for which percutaneous angioplasty is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 97%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 98%

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of angioplasty balloons, wires, catheters and insufflation devices which may be required, and ensure availability. Assess need for stand-by devices that might be needed emergently (eg, covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: The operator administers or supervises administration of moderate sedation. A guidewire is passed through the transitional sheath previously placed for angiography (separately coded) and advanced in a retrograde direction to the periarterial anastomosis. The transitional sheath is exchanged for a larger caliber sidearm exchange sheath. A guidewire and diagnostic catheter are then directed under fluoroscopic guidance through the arterial anastomosis and retrograde into the proximal artery; catheter manipulation may be required (separately coded). Once the catheter is positioned in the proximal artery, contrast is injected for antegrade angiogram imaging of the distal artery, the arterial anastomosis, and the juxta anastomotic access, and to clarify the degree of stenosis. An angioplasty balloon catheter is selected for size and estimated inflation pressure requirements to successfully dilate the stenosis. A guidewire is

reinserted, the diagnostic catheter removed, and, using fluoroscopy, the balloon catheter is positioned in the artery bridging the stenosis. Under fluoroscopic guidance, the balloon is inflated to complete balloon effacement. The balloon catheter is then withdrawn, a diagnostic catheter reinserted into the proximal artery, contrast injected, and a follow-up antegrade angiogram performed. Typically , the stenosis is persistent and additional inflation procedures with the same (or new) angioplasty balloon catheters are required. Upon successful dilation of the stenosis, a final antegrade angiogram is performed to verify that no vessel rupture has occurred and that there is unrestricted flow into the AV access with appropriate contrast runoff. The catheter, guidewire, and sheath are then sequentially removed, and hemostasis of the venotomy site achieved using manual compression or surgical closure.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor AV shunt puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). All appropriate medical records are completed, with copy to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Sean Tutton, M.D., Michael Hall, M.D., Robert L Vogelzang, M.D., Gerald A. Niedzwiecki, M.D., Robert Kossmann, M.D., and Chet Amedia, M.D.		
Specialty(s):	SIR, ACR, RPA		
CPT Code:	35475		
Sample Size:	2166	**Resp N:** 84	**Response:** 3.8 %
Description of Sample:	The specialty societies performed a random survey of diagnostic radiologists, interventional radiologists and interventional nephrologists. In addition, the specialty societies convened an expert panel to review the survey data.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	9.00	**20.00**	68.00	850.00
Survey RVW:	4.20	7.00	**8.10**	9.54	20.00
Pre-Service Evaluation Time:			**29.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	6.00	30.00	**43.00**	60.00	120.00

Immediate Post Service-Time:	**23.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	35475	**Recommended Physician Work RVU: 6.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**4.00**	**1.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**43.00**		

Immediate Post Service-Time:	**23.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37224	000	9.00	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52344	000	7.05	**RUC Time**	2,654

CPT Descriptor 1 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
37220	000	8.15	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 35475**	**Key Reference CPT Code:** 37224	**Source of Time RUC Time**
Median Pre-Service Time	26.00	48.00	
Median Intra-Service Time	43.00	80.00	
Median Immediate Post-service Time	23.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**92.00**	**158.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.81	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.67
Urgency of medical decision making	3.62	3.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.43	4.05
Physical effort required	4.10	3.90
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.38	4.52
Outcome depends on the skill and judgment of physician	4.14	4.24
Estimated risk of malpractice suit with poor outcome	4.43	4.19

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	4.05
Intra-Service intensity/complexity	3.76	3.52
Post-Service intensity/complexity	4.00	3.57

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. 75962 - Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation
4. 36147- Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
5.

6. CPT	Descriptor	Global	RVU	Pre	Intra	Post	Total time	Source
7. 75962	Transluminal balloon angio	XXX	0.54				12	CMS/Other
8. 36147	Introduction of needle/ catheter	XXX	3.72	20	45	15	80	RUC

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35475

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nephrology How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Specialty Interventional Radiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 103206
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 35475 provided nationally in a one-year period is estimated to be 103,206.

Specialty Nephrology Frequency 30518 Percentage 29.56 %

Specialty Diagnostic Radiology Frequency 22314 Percentage 21.62 %

Specialty Interventional Radiology Frequency 10228 Percentage 9.91 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 34,402 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that CPT code 35475 was billed approximately 34,402 times for Medicare patients nationally in a one-year period.

Specialty Nephrology Frequency 10173 Percentage 29.57 %

Specialty Diagnostic Radiology Frequency 7441 Percentage 21.62 %

Specialty Interventional Radiology Frequency 3410 Percentage 9.91 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 35475

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:35476 Tracking Number Original Specialty Recommended RVU: **5.10**
Presented Recommended RVU: **5.10**
Global Period: 000 RUC Recommended RVU: **5.10**

CPT Descriptor: Transluminal balloon angioplasty, percutaneous; venous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year old woman with chronic kidney disease has an upper extremity AV hemodialysis access, with signs and symptoms of outflow stenosis. The AV shunt is accessed (separately reported) and angiography of the outflow vessels performed (separately reported) revealing a stenosis of the venous outflow for which percutaneous angioplasty is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 95%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 98%

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of angioplasty balloons, wires, catheters and insufflation devices which may be required, and ensure availability. Assess need for stand-by devices that might be needed emergently (eg, covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: After the outflow stenosis has been identified (separate), the operator administers or supervises administration of moderate sedation. A guidewire is passed through the transitional sheath previously placed for angiography and advanced in an antegrade direction through the fistula, draining and central veins, to terminate in the superior vena cava. The transitional sheath is exchanged for a larger caliber exchange sheath with a sidearm port. An angioplasty balloon catheter is selected for size and estimated inflation pressure requirements to successfully dilate the identified stenosis. Using fluoroscopy, the balloon catheter is positioned in the vein to bridge the stenosis. Under fluoroscopic guidance, the balloon is inflated to complete balloon effacement. The angioplasty balloon catheter is then

withdrawn and contrast injected to perform a follow-up antegrade angiogram. Typically, the stenosis is persistent and additional inflation procedures with the same (or new) angioplasty balloon catheters are required. Upon successful dilation of the stenosis, a final antegrade angiogram is performed to verify that no vessel rupture has occurred and that there is unrestricted flow into the draining veins. The catheter, guidewire, and sheath are then sequentially removed, and hemostasis of the venotomy site achieved using manual compression or surgical closure.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Monitor AV shunt puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). All appropriate medical records are completed, with copy to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Sean Tutton, M.D., Michael Hall, M.D., Robert L Vogelzang, M.D., Gerald A. Niedzwiecki, M.D., Robert Kossmann, M.D., and Chet Amedia, M.D.		
Specialty(s):	SIR, ACR, RPA		
CPT Code:	35476		
Sample Size:	2166	**Resp N:** 85	**Response:** 3.9 %
Description of Sample:	The specialty societies performed a random survey of diagnostic and interventional radiologists and interventional nephrologists. The specialty societies convened an expert panel to review survey data.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	30.00	**60.00**	265.00	963.00
Survey RVW:	3.95	5.10	**6.55**	8.00	20.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	6.00	30.00	**35.00**	50.00	90.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	35476	**Recommended Physician Work RVU: 5.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**4.00**	**1.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37220	000	8.15	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,473

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
37191	000	4.71	**RUC Time**

CPT Descriptor Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 21.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 35476**	**Key Reference CPT Code:** 37220	**Source of Time RUC Time**
Median Pre-Service Time	26.00	48.00	
Median Intra-Service Time	35.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**81.00**	**138.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.94	3.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.11
Urgency of medical decision making	3.39	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.44	3.22
Physical effort required	3.44	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.61
Outcome depends on the skill and judgment of physician	3.39	3.72
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.94	3.06
Intra-Service intensity/complexity	3.11	3.39
Post-Service intensity/complexity	3.28	3.44

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. 75978 - Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation
4. 36147- Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
5.
6.
7.
8.

CPT	Descriptor	Global	RVU	Pre	Intra	Post	Total time	Source
75978	Transluminal balloon angio	XXX	0.54				12	CMS/Other
36147	Introduction of needle/catheter	XXX	3.72	20	45	15	80	RUC

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35476

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Nephrology How often? Commonly

Specialty Interventional Radiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 786450
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 35476 provided nationally in a one-year period is estimated to be 786,450.

Specialty Diagnostic Radiology Frequency 264483 Percentage 33.62 %

Specialty Nephrology Frequency 204792 Percentage 26.04 %

Specialty Interventional Radiology Frequency 73533 Percentage 9.34 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 262,150 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that CPT code 35476 was billed approximately 262,150 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 88161 Percentage 33.62 %

Specialty Nephrology Frequency 68264 Percentage 26.04 %

Specialty Interventional Radiology Frequency 24511 Percentage 9.34 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 35476

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Repair of Arterial and Venous Blockage

TAB: 41

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with translu	21	0.092			9.00			158	40	3	5			80			30
CURRENT	75962	Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extrem		#DIV/0!			0.54			12									
CURRENT	35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel		0.075			9.48			12						90			121
SVY	35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	84	0.154	4.20	7.00	8.10	9.54	20.00	115	29	10	10	6	30	43	60	120	23
REC	35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel		0.130			6.60			92	17	4	5			43			23

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with translum	18	0.108			8.15			138	40	3	5			60			30
CURRENT	35476	Transluminal balloon angioplasty, percutaneous; venous		0.059			6.03			145						75			70
CURRENT	75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation		#DIV/0!			0.54			12									
SVY	35476	Transluminal balloon angioplasty, percutaneous; venous	85	0.150	3.95	5.10	6.55	8.00	20.00	100	25	10	10	6	30	35	50	90	20
REC	35476	Transluminal balloon angioplasty, percutaneous; venous		0.118			5.10			81	17	4	5			35			20

CPT Code: 35475 & 35476
Specialty Society('s) SIR, ACR, & RPA

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
35475 – Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476 - Transluminal balloon angioplasty, percutaneous; venous

Global Period: 000 Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Society of Interventional Radiology, American College of Radiology, and the Renal Physicians Association convened a consensus panel to review and finalize the practice expense data for codes 35475 and 35476.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Since 35475 and 35476 are existing codes, we used the PEAC-approved data as the basis for the practice expense inputs for code 35475 and 35476.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

CPT Code: 35475 & 35476
Specialty Society('s) SIR, ACR, & RPA

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
35475 – Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476 – Transluminal balloon angioplasty, percutaneous; venous

Global Period: 000 Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Society of Interventional Radiology, American College of Radiology, and the Renal Physicians Association convened a consensus panel to review and finalize the practice expense data for codes 35475 and 35476.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Since 35475 and 35476 are existing codes, we used the PEAC-approved data as the basis for the practice expense inputs for codes 35475 and 35476.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:
- Review charts
- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Sedate/apply anesthesia
- Assist physician in performing procedure
- Assist physician/ CS monitoring
- Assist MD with image acquisition
- Circulate throughout procedure
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1																							
2	**Tab 41: Revised 04/26/2012**			**75964**		**75964**		**35475**		**35475**		**35475**		**75978**		**75978**		**35476**		**35476**		**35476**	
3	**Meeting Date: April 2012** **Tab: 41** **Specialty: ACR, RPA, SIR**	**CMS Code**	**Staff Type**	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(April 2012)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; venous **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(April 2012)**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**	**000**	**000**	**000**	**000**	**XXX**	**XXX**	**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL TIME**	**L037D**		**41.0**	**0.0**	**41.0**	**0.0**	**224.0**	**26.0**	**224.0**	**23.0**	**332.0**	**44.0**	**90.0**	**0.0**	**90.0**	**0.0**	**191.0**	**26.0**	**191.0**	**0.0**	**354.0**	**40.0**
7	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**5.0**	**0.0**	**5.0**	**0.0**	**30.0**	**26.0**	**30.0**	**23.0**	**36.0**	**23.0**	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**26.0**	**30.0**	**0.0**	**34.0**	**40.0**
8		**L041B**	**RT**	**36.0**	**0.0**	**36.0**	**0.0**	**81.0**	**0.0**	**81.0**	**0.0**	**41.0**	**0.0**	**90.0**	**0.0**	**90.0**	**0.0**	**69.0**	**0.0**	**69.0**	**0.0**	**35.0**	**0.0**
9		**L051A**	**RN**	**0.0**	**0.0**	**0.0**	**0.0**	**113.0**	**0.0**	**113.0**	**0.0**	**212.0**	**21.0**	**0.0**	**0.0**	**0.0**	**0.0**	**92.0**	**0.0**	**92.0**	**0.0**	**97.0**	**0.0**
10		**L014A**	**Angio Tech**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**43.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**188.0**	**0.0**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**0.0**	**5.0**	**0.0**	**9.0**	**23.0**	**9.0**	**23.0**	**9.0**	**23.0**	**0.0**	**0.0**	**0.0**	**0.0**	**9.0**	**23.0**	**9.0**	**0.0**	**9.0**	**19.0**
12		**L041B**	**RT**	**0.0**	**0.0**	**36.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
13		**L014A**	**Angio Tech**																			**0.0**	**21.0**
14	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**5.0**	**0.0**	**0.0**	**0.0**	**18.0**	**0.0**	**18.0**	**0.0**	**27.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**18.0**	**0.0**	**18.0**	**0.0**	**25.0**	**0.0**
15		**L041B**	**RT**	**36.0**	**0.0**	**0.0**	**0.0**	**81.0**	**0.0**	**81.0**	**0.0**	**41.0**	**0.0**	**84.0**	**0.0**	**84.0**	**0.0**	**69.0**	**0.0**	**69.0**	**0.0**	**35.0**	**0.0**
16		**L051A**	**RN**	**0.0**	**0.0**	**0.0**	**0.0**	**113.0**	**0.0**	**113.0**	**0.0**	**212.0**	**21.0**	**0.0**	**0.0**	**0.0**	**0.0**	**92.0**	**0.0**	**92.0**	**0.0**	**97.0**	**0.0**
17		**L014A**	**Angio Tech**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**43.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**188.0**	**0.0**
18	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**
19	**PRE-SERVICE**																						
20	**Start: Following visit when decision for surgery or procedure made**																						
21	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA					**3**	**5**			**3**	**3**					**3**	**5**			**3**	**3**
22	Coordinate pre-surgery services	L037D	RN/LPN/MTA					**3**	**10**			**3**	**10**					**3**	**10**			**3**	**10**
23	Schedule space and equipment in facility	L037D	RN/LPN/MTA						**5**				**5**						**5**				**5**
24	Provide pre-service education/obtain consent																						
25	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA					**3**	**3**			**3**	**3**					**3**	**3**			**3**	**3**
26	Other Clinical Activity - *specify: Retrieve prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD*	L041B	RT											**6**									
27	**End: When patient enters office/facility for surgery/procedure**																						
28	**SERVICE PERIOD**																						
29	**Start: When patient enters office/facility for surgery/procedure:**																						
30	Review charts	L037D	RN/LPN/MTA					**2**										**2**					
31	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA					**3**				**3**						**3**				**3**	
32	Obtain vital signs	L037D	RN/LPN/MTA					**5**				**3**						**5**				**3**	
33	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**5**				**5**				**5**						**5**				**5**	
34	Prepare room, equipment, supplies	L041B	RT					**4**				**2**		**3**				**4**				**2**	
35	Setup scope (non facility setting only)																						
36	Prepare and position patient/ monitor patient/ set up IV	L041B	RT					**2**				**2**						**2**				**2**	
37	Sedate/apply anesthesia	L051A	RN					**2**				**2**						**2**				**2**	
38	**Intra-service**																						

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1																							
2	**Tab 41: Revised 04/26/2012**			**75964**		**75964**		**35475**		**35475**		**35475**		**75978**		**75978**		**35476**		**35476**		**35476**	
3	**Meeting Date: April 2012** **Tab: 41** **Specialty: ACR, RPA, SIR**	**CMS Code**	**Staff Type**	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(April 2012)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; venous **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(April 2012)**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**	**000**	**000**	**000**	**000**	**XXX**	**XXX**	**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
39	Assist physician in performing procedure @ 100%	L014A	Angio Tech					**72**				**43**						**60**				35	
40	Assist physician/ CS monitoring @100%	L051A	RN					**90**				**43**						**75**				**35**	
41	Assist MD with image acquisition @75%	L041B	RT	**3**								**32**		**7**								**26**	
42	Circulate throughout procedure@ 25%	L037D	RN/LPN/MTA	**30**								**11**		**68**								**9**	
43	**Post-Service**																						
44	Monitor pt. following service/check tubes, monitors, drains	L051A	RN					**21**				**60**						**15**				**60**	
45	Clean room/equipment by physician staff	L041B	RT					**3**				**3**		**3**				**3**				**3**	
46	Clean Scope	L037D	RN/LPN/MTA																				
47	Clean Surgical Instrument Package																						
48	Complete diagnostic forms, lab & X-ray requisitions																						
49	Review/read X-ray, lab, and pathology reports																						
50	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA					**3**				**3**						**3**				**3**	
51	Other Clinical Activity - *specify: Process and hang films*	L041B	RT	**3**										**3**									
52	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
53	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
54	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
55	**End: Patient leaves office**																						
56	**POST-SERVICE Period**																						
57	**Start: Patient leaves office/facility**																						
58	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA					**3**	**3**									**3**	**3**				
59	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
60	99211 16 minutes		16																				
61	99212 27 minutes		27																				
62	99213 36 minutes		36																				
63	99214 53 minutes		53																				
64	99215 63 minutes		63																				
65	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
66	Other Clinical Activity - *specify:*																						
67	**End: with last office visit before end of global period**																						

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1																							
2	**Tab 41: Revised 04/26/2012**			**75964**		**75964**		**35475**		**35475**		**35475**		**75978**		**75978**		**35476**		**35476**		**35476**	
3	**Meeting Date: April 2012** **Tab: 41** **Specialty: ACR, RPA, SIR**	**CMS Code**	**Staff Type**	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(April 2012)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; venous **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(April 2012)**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**	**000**	**000**	**000**	**000**	**XXX**	**XXX**	**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
68	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																				
69	pack, minimum multi-specialty visit	SA048	pack					**1**		**1**		**1**						**1**		**1**		**1**	
70	pack, moderate sedation	SA044	pack					**1**		**1**		**1**						**1**		**1**		**1**	
71	gown, surgical, sterile *[one included with CS pack]*	SB028	item					**1**		**1**		**1**						**2**		**2**		**1**	
72	gloves, sterile *[one pair included with CS pack]*	SB024	pair					**1**		**1**		**1**						**2**		**2**		**1**	
73	mask, surgical, with face shield	SB034	item					**2**		**2**		**2**						**3**		**3**		**2**	
74	cap, surgical	SB001	item					**2**		**2**		**3**						**3**		**3**		**3**	
75	shoe covers, surgical	SB039	pair					**2**		**2**		**3**						**3**		**3**		**3**	
76	drape-towel, sterile 18inx26in	SB019	item					**4**		**4**		**4**						**2**		**2**		**4**	
77	drape, sterile, three-quarter sheet	SB014	item					**1**		**1**		**1**						**1**		**1**		**1**	
78	drape, sterile, fenestrated 16in x 29in	SB011	item					**1**		**1**		**1**						**1**		**1**		**1**	
79	povidone soln (Betadine)	SJ041	ml					**10**		**10**								**10**		**10**			
80	guidewire, hydrophilic	SD089	item					**1**		**1**		**1**						**1**		**1**		**1**	
81	guidewire, steerable (Hi-Torque)	SD174	item					**1**		**1**		**1**						**1**		**1**		**1**	
82	guidewire, torque	SD176	item					**1**		**1**		**1**						**1**		**1**		**1**	
83	catheter, balloon, PTA	SD152	item					**2**		**2**		**2**						**2**		**2**		**2**	
84	catheter, balloon inflation device	SD149	item					**1**		**1**		**1**						**1**		**1**		**1**	
85	gauze, sterile 4in x 4in	SG055	item					**2**		**2**								**2**		**2**			
86	tape, surgical paper 1in (Micropore)	SG079	in					**6**		**6**		**6**						**6**		**6**		**6**	
87	Conray Inj (iothalamate 43%)	SH026	ml	**25**										**25**									
88	drape, sterile, c-arm, fluoro	SB008	item											**1**		**1**							
89	x-ray ID card (flashcard)	SK093	item											**1**		**1**							
90	x-ray envelope	SK091	item											**1**		**1**							
91	film, x-ray 14inx17in	SK034	item	**2**										**2**									
92	x-ray developer solution	SK089	oz	**1**										**1**									
93	x-ray fixer solution	SK092	0z	**1**										**1**									
94	disinfectant, surface (Envirocide, Sanizide)	SM013	oz											**1**		**1**							
95	computer media, dvd	SK013	item											**1**		**1**							
96	suture device for vessel closure (Perclose A-T)	SD207	item					**1**		**1**													
97	film, x-ray, laser print	SK098	item			**2**										**2**							
98	**EQUIPMENT**	**CODE**																					
99	Room, angiography	EL011		**9**		**9**		**92**		**92**		**51**		**9**		**9**		**77**		**77**		**43**	
100	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011						**X**		**212**		**212**						**X**		**137**		**137**	
101	IV infusion pump	EQ032						**X**		**212**		**212**						**X**		**137**		**137**	
102	Light, exam	EQ168						**X**		**120**		**120**						**X**		**120**		**120**	
103	Table, instrument, mobile	EF027								**212**		**285**								**137**		**302**	
104	film alternator (motorized film viewbox)	ER029		**X**		**3**		**X**						**X**		**3**							
105	film printer, laser	ED032		**X**				**X**						**X**									
106	film processor, dry, laser	ED024				**3**										**3**							
107	stretcher chair	EF019						**X**										**X**					
108	oxygen system, portable	EQ192						**X**										**X**					
109	pulse oximeter w-printer	EQ211																**X**					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1																							
2	**Tab 41: Revised 04/26/2012**			**75964**		**75964**		**35475**		**35475**		**35475**		**75978**		**75978**		**35476**		**35476**		**35476**	
3	**Meeting Date: April 2012** **Tab: 41** **Specialty: ACR, RPA, SIR**	**CMS Code**	**Staff Type**	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(April 2012)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; venous **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(April 2012)**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**	**000**	**000**	**000**	**000**	**XXX**	**XXX**	**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL TIME**	**L037D**		**41.0**	**0.0**	**41.0**	**0.0**	**224.0**	**26.0**	**224.0**	**23.0**	**225.0**	**23.0**	**90.0**	**0.0**	**90.0**	**0.0**	**191.0**	**26.0**	**191.0**	**0.0**	**201.0**	**19.0**
7	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**5.0**	**0.0**	**5.0**	**0.0**	**30.0**	**26.0**	**30.0**	**23.0**	**36.0**	**23.0**	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**26.0**	**30.0**	**0.0**	**34.0**	**19.0**
8		**L041B**	**RT**	**36.0**	**0.0**	**36.0**	**0.0**	**81.0**	**0.0**	**81.0**	**0.0**	**41.0**	**0.0**	**90.0**	**0.0**	**90.0**	**0.0**	**69.0**	**0.0**	**69.0**	**0.0**	**35.0**	**0.0**
9		**L051A**	**RN**	**0.0**	**0.0**	**0.0**	**0.0**	**113.0**	**0.0**	**113.0**	**0.0**	**105.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**92.0**	**0.0**	**92.0**	**0.0**	**97.0**	**0.0**
10		**L014A**	**Angio Tech**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**43.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**35.0**	**0.0**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**0.0**	**5.0**	**0.0**	**9.0**	**23.0**	**9.0**	**23.0**	**9.0**	**23.0**	**0.0**	**0.0**	**0.0**	**0.0**	**9.0**	**23.0**	**9.0**	**0.0**	**9.0**	**19.0**
12		**L041B**	**RT**	**0.0**	**0.0**	**36.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
13	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**5.0**	**0.0**	**0.0**	**0.0**	**18.0**	**0.0**	**18.0**	**0.0**	**27.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**18.0**	**0.0**	**18.0**	**0.0**	**25.0**	**0.0**
14		**L041B**	**RT**	**36.0**	**0.0**	**0.0**	**0.0**	**81.0**	**0.0**	**81.0**	**0.0**	**41.0**	**0.0**	**84.0**	**0.0**	**84.0**	**0.0**	**69.0**	**0.0**	**69.0**	**0.0**	**35.0**	**0.0**
15		**L051A**	**RN**	**0.0**	**0.0**	**0.0**	**0.0**	**113.0**	**0.0**	**113.0**	**0.0**	**105.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**92.0**	**0.0**	**92.0**	**0.0**	**97.0**	**0.0**
16		**L014A**	**Angio Tech**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**43.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**35.0**	**0.0**
17	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**
18	**PRE-SERVICE**																						
19	**Start: Following visit when decision for surgery or procedure made**																						
20	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA					**3**	**5**			**3**	**5**					**3**	**5**			**3**	**3**
21	Coordinate pre-surgery services	L037D	RN/LPN/MTA					**3**	**10**			**3**	**10**					**3**	**10**			**3**	**10**
22	Schedule space and equipment in facility	L037D	RN/LPN/MTA						**5**				**5**						**5**				**3**
23	Provide pre-service education/obtain consent																						
24	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA					**3**	**3**			**3**	**3**					**3**	**3**			**3**	**3**
25	Other Clinical Activity - *specify: Retrieve prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD*	L041B	RT											**6**									
26	**End: When patient enters office/facility for surgery/procedure**																						
27	**SERVICE PERIOD**																						
28	**Start: When patient enters office/facility for surgery/procedure:**																						
29	Review charts	L037D	RN/LPN/MTA					**2**										**2**					
30	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA					**3**				**3**						**3**				**3**	
31	Obtain vital signs	L037D	RN/LPN/MTA					**5**				**5**						**5**				**5**	
32	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**5**				**5**				**5**						**5**				**5**	
33	Prepare room, equipment, supplies	L041B	RT					**4**				**4**		**3**				**4**				**4**	
34	Setup scope (non facility setting only)																						
35	Prepare and position patient/ monitor patient/ set up IV	L041B	RT					**2**				**2**						**2**				**2**	
36	Sedate/apply anesthesia	L051A	RN					**2**				**2**						**2**				**2**	
37	**Intra-service**																						

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1																							
2	**Tab 41: Revised 04/26/2012**			**75964**		**75964**		**35475**		**35475**		**35475**		**75978**		**75978**		**35476**		**35476**		**35476**	
3	**Meeting Date: April 2012** **Tab: 41** **Specialty: ACR, RPA, SIR**	**CMS Code**	**Staff Type**	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(April 2012)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; venous **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(April 2012)**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**	**000**	**000**	**000**	**000**	**XXX**	**XXX**	**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
38	Assist physician in performing procedure @ 100%	L014A	Angio Tech					**72**				**43**						**60**				35	
39	Assist physician/ CS monitoring @100%	L051A	RN					**90**				**43**						**75**				**35**	
40	Assist MD with image acquisition @75%	L041B	RT	**3**								**32**		**7**								**26**	
41	Circulate throughout procedure@ 25%	L037D	RN/LPN/MTA	**30**								**11**		**68**								**9**	
42	**Post-Service**																						
43	Monitor pt. following service/check tubes, monitors, drains	L051A	RN					**21**				**60**						**15**				**60**	
44	Clean room/equipment by physician staff	L041B	RT					**3**				**3**		**3**				**3**				**3**	
45	Clean Scope	L037D	RN/LPN/MTA																				
46	Clean Surgical Instrument Package																						
47	Complete diagnostic forms, lab & X-ray requisitions																						
48	Review/read X-ray, lab, and pathology reports																						
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA					**3**				**3**						**3**				**3**	
50	Other Clinical Activity - *specify: Process and hang films*	L041B	RT	**3**										**3**									
51	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
52	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
53	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
54	**End: Patient leaves office**																						
55	**POST-SERVICE Period**																						
56	**Start: Patient leaves office/facility**																						
57	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA					**3**	**3**									**3**	**3**				
58	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
59	99211 16 minutes		16																				
60	99212 27 minutes		27																				
61	99213 36 minutes		36																				
62	99214 53 minutes		53																				
63	99215 63 minutes		63																				
64	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
65	Other Clinical Activity - *specify:*																						
66	**End: with last office visit before end of global period**																						

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1																							
2	**Tab 41: Revised 04/26/2012**			**75964**		**75964**		**35475**		**35475**		**35475**		**75978**		**75978**		**35476**		**35476**		**35476**	
3	**Meeting Date: April 2012** **Tab: 41** **Specialty: ACR, RPA, SIR**	**CMS Code**	**Staff Type**	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel **(April 2012)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(PEAC approved - Jan 2004)**		Transluminal balloon angioplasty, percutaneous; venous **(Current RUC DB)**		Transluminal balloon angioplasty, percutaneous; venous **(April 2012)**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**	**000**	**000**	**000**	**000**	**XXX**	**XXX**	**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
67	**MEDICAL SUPPLIES**	**CODE**	**UNIT**																				
68	pack, minimum multi-specialty visit	SA048	pack					**1**		**1**		**1**						**1**		**1**		**1**	
69	pack, moderate sedation	SA044	pack					**1**		**1**		**1**						**1**		**1**		**1**	
70	gown, surgical, sterile *[one included with CS pack]*	SB028	item					**1**		**1**		**1**						**2**		**2**		**1**	
71	gloves, sterile *[one pair included with CS pack]*	SB024	pair					**1**		**1**		**1**						**2**		**2**		**1**	
72	mask, surgical, with face shield	SB034	item					**2**		**2**		**2**						**3**		**3**		**2**	
73	cap, surgical	SB001	item					**2**		**2**		**3**						**3**		**3**		**3**	
74	shoe covers, surgical	SB039	pair					**2**		**2**		**3**						**3**		**3**		**3**	
75	drape-towel, sterile 18inx26in	SB019	item					**4**		**4**		**4**						**2**		**2**		**4**	
76	drape, sterile, three-quarter sheet	SB014	item					**1**		**1**		**1**						**1**		**1**		**1**	
77	drape, sterile, fenestrated 16in x 29in	SB011	item					**1**		**1**		**1**						**1**		**1**		**1**	
78	povidone soln (Betadine)	SJ041	ml					**10**		**10**								**10**		**10**			
79	guidewire, hydrophilic	SD089	item					**1**		**1**		**1**						**1**		**1**		**1**	
80	guidewire, steerable (Hi-Torque)	SD174	item					**1**		**1**		**1**						**1**		**1**		**1**	
81	guidewire, torque	SD176	item					**1**		**1**		**1**						**1**		**1**		**1**	
82	catheter, balloon, PTA	SD152	item					**2**		**2**		**2**						**2**		**2**		**2**	
83	catheter, balloon inflation device	SD149	item					**1**		**1**		**1**						**1**		**1**		**1**	
84	gauze, sterile 4in x 4in	SG055	item					**2**		**2**								**2**		**2**			
85	tape, surgical paper 1in (Micropore)	SG079	in					**6**		**6**		**6**						**6**		**6**		**6**	
86	Conray Inj (iothalamate 43%)	SH026	ml	**25**										**25**									
87	drape, sterile, c-arm, fluoro	SB008	item											**1**		**1**							
88	x-ray ID card (flashcard)	SK093	item											**1**		**1**							
89	x-ray envelope	SK091	item											**1**		**1**							
90	film, x-ray 14inx17in	SK034	item	**2**										**2**									
91	x-ray developer solution	SK089	oz	**1**										**1**									
92	x-ray fixer solution	SK092	0z	**1**										**1**									
93	disinfectant, surface (Envirocide, Sanizide)	SM013	oz											**1**		**1**							
94	computer media, dvd	SK013	item											**1**		**1**							
95	suture device for vessel closure (Perclose A-T)	SD207	item					**1**		**1**													
96	film, x-ray, laser print	SK098	item			**2**										**2**							
97	**EQUIPMENT**	**CODE**																					
98	Room, angiography	EL011		**9**		**9**		**92**		**92**		**51**		**9**		**9**		**77**		**77**		**43**	
99	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011						**X**		**212**		**212**						**X**		**137**		**137**	
100	IV infusion pump	EQ032						**X**		**212**		**212**						**X**		**137**		**137**	
101	Light, exam	EQ168						**X**		**120**		**120**						**X**		**120**		**120**	
102	Table, instrument, mobile	EF027								**212**		**285**								**137**		**302**	
103	film alternator (motorized film viewbox)	ER029		**X**		**3**		**X**						**X**		**3**							
104	film printer, laser	ED032		**X**				**X**						**X**									
105	film processor, dry, laser	ED024				**3**										**3**							
106	stretcher chair	EF019						**X**										**X**					
107	oxygen system, portable	EQ192						**X**										**X**					
108	pulse oximeter w-printer	EQ211																**X**					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request - NPRM for 2012

April 2012

Cholecystectomy

In the Notice for Proposed Rulemaking, CMS indicated that the agency received comments regarding a potential relativity problem between CPT codes 47600 *Cholecystectomy*; and 47605 *Cholecystectomy; with cholangiography*. It appears that the visits do not appropriately reflect the relativity of these two services, and 47600 should not have more time and visits associated with the service than 47605. The specialty society recognized that the value for code 47605 may be incorrect. The RUC recommended that codes 47600 and 47605 be resurveyed for physician work and practice expense.

The specialty societies indicated and the RUC agreed that there is compelling evidence that the typical patient receiving these services have changed. In current practice, the typical patient undergoing an open procedure has been converted from a laparoscopic approach due to severity of disease, difficult adhesions from prior abdominal surgery and/or difficulties with defining ductal and other anatomy. The specialty societies indicated that more than 80% of Medicare patients undergoing open cholecystectomy are scheduled and started as laparoscopic and are then converted to open. Per Medicare guidelines, only the definitive procedure can be reported, and in this instance, it would be the open procedures 47600 or 47605. The physician reports the open procedure and ICD-9 code V64.41 *Laparoscopic surgical procedure converted to open procedure*. The American College of Surgeons summarizes the rationale and approval process for the vignettes for 47600 and 47605 in the attached memorandum.

47600 Cholecystectomy
In April 2012, the RUC reviewed the survey results from 50 general surgeons and determined that the survey median work RVU of 20.00 and intra-service time of 120 minutes appropriately account for the physician work and time required to perform this service. The survey respondents indicated and the RUC agreed that 2-99232 *Subsequent hospital care visits* are appropriate to care for this typical patient who has had been converted to an open procedure. The RUC compared 47600 to the key reference service 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59 and 150 minutes intra-service time) and determined that 44140 requires 30 minutes more intra-service time and more physician work to perform. For further support, the RUC compared 47600 to similar MPC code 38100 *Splenectomy; total (separate procedure)* (work RVU = 19.55 and 120 intra-service time) and 49203 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less* (work RVU = 20.13 and 120 minutes intra-service time) and determined that a work RVU of 20.00 for 47600 places this service in proper rank order. **The RUC recommends a work RVU of 20.00 for CPT code 47600.**

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47605 Cholecystectomy; with cholangiography
In April 2012, the RUC reviewed the survey results from 50 general surgeons and determined that the survey median work RVU of 21.00 and intra-service time of 135 minutes appropriately account for the physician work and time required to perform this service. The survey respondents indicated and the RUC agreed that two 99232 *Subsequent hospital care visits* are appropriate to care for this typical patient who has had been converted to an open procedure. The RUC compared 47605 to the key reference service 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59 and 150 minutes intra-service time) and determined that 44140 requires 15 minutes more intra-service time and more physician work to perform. The RUC noted that the median value of 21.00 for CPT code 47605 and significant increases to intra-time and post-op work addresses the current rank order anomaly and places this service in the proper rank order with 47600. For further support, the RUC compared 47605 to similar MPC code 38100 *Splenectomy; total (separate procedure)* (work RVU = 19.55 and 120 intra-service time) and 33883 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension* (work RVU = 21.09 and 120 minutes intra-service time), which is more intense and complex to perform, but requires less post-operative visits than 47605. **The RUC recommends a work RVU of 21.00 for CPT code 47605.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
47600		Cholecystectomy;	090	20.00
47605		with cholangiography	090	21.00

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Date: May 7, 2012

To: Barbara Levy
Chair, AMA/Relative Value Update Committee

From: Christopher Senkowski, MD, FACS, ACS RUC Advisor
Don Selzer, MD, FACS, SAGES RUC Advisor

Subject: Typical Patient Undergoing Open Cholecystectomy

At the request of CMS, the American College of Surgeons and the Society of American Gastrointestinal and Endoscopic Surgeons recently conducted an American Medical Association Relative Value Scale Update Committee (AMA RUC) survey for codes 47600 *Cholecystectomy* and 47605 *Cholecystectomy; with cholangiography*. During the presentation of physician work recommendations at the April RUC meeting, a question was raised regarding the typical patient vignettes on the surveys.

We would like to take this opportunity to provide the information presented to the AMA RUC Research Subcommittee regarding the typical patient, along with the supporting peer-reviewed literature. Because the Centers for Medicare and Medicaid Services (CMS) may not have been included on the Research Subcommittee conference call and follow-up e-mails where this information was discussed, we would also request that this information be forwarded to CMS with the AMA RUC recommendations.

The 2005 vignette for 47600 indicated the typical patient was a *scheduled* open procedure. Code 47605, which was last surveyed in 2000 as a mini-survey, did not have a vignette. Prior to conducting the current AMA RUC survey, the College convened an expert panel of general surgeons who perform both laparoscopic cholecystectomy (LC) and open cholecystectomy (OC) to discuss the vignettes for these two codes. The expert panel was in total agreement that, unlike other major abdominal procedures (e.g., colectomy), in current clinical practice, cholecystectomy is typically performed laparoscopically. In addition, a review of literature indicates that the *typical* patient in current practice who undergoes OC is an LC to OC conversion and not a scheduled OC.

There are many reasons to convert from LC to OC, including severity of disease, adhesions from prior abdominal surgery and/or difficulties with defining ductal anatomy. As the *rate* of OC compared with LC decreases (significantly), the *percentage* of patients undergoing conversion at operation has increased, such that the *typical* patient is now an LC to OC conversion. Based on this information, the Research Subcommittee discussed and then approved survey vignettes that describe LC to OC conversion as the typical patient for 47600 and 47605. This methodology of reviewing physician work related to the typical patient is consistent with every other vignette used for an AMA RUC survey and is consistent with valuing physician work.

As Table 1 shows, the total number of cholecystectomies has declined 12 percent since the year the previous vignette was written for 47600 (2004). This decrease is the result of medical management and non-surgical interventions for treating gall bladder disease.

Table 1 also shows that the percentage of OC compared with LC has declined significantly (20% to 11%). In the non-Medicare-aged population, OC is performed significantly less often than LC. A national study of over 80,000 patients undergoing cholecystectomy from 1999-2005 indicated the percentage of OC compared with LC was ten percent.[1]

Table 1								
Medicare Data	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Total LC+OC	**220,537**	**218,517**	**212,898**	**204,341**	**199,686**	**200,169**	**197,251**	**194,390**
47562	119,297	119,456	118,151	115,186	113,620	115,338	116,093	116,224
47563	63,776	64,477	63,758	61,696	60,593	60,908	59,873	58,849
LC	**183,073**	**183,933**	**181,909**	**176,882**	**174,213**	**176,246**	**175,966**	**175,073**
% total LC+OC	*83%*	*84%*	*85%*	*87%*	*87%*	*88%*	*89%*	*90%*
47600	29,510	27,293	24,568	21,891	20,444	19,233	17,084	15,541
47605	7,954	7,291	6,421	5,568	5,029	4,690	4,201	3,776
OC	**37,464**	**34,584**	**30,989**	**27,459**	**25,473**	**23,923**	**21,285**	**19,317**
% total LC+OC	*17%*	*16%*	*15%*	*13%*	*13%*	*12%*	*11%*	*10%*
OC as % of LC	***20%***	***19%***	***17%***	***16%***	***15%***	***14%***	***12%***	***11%***

Notes: LC refers to laparoscopic cholecystectomy. OC refers to open cholecystectomy.

A review of recent literature indicates that the national rate of LC to OC conversion varies annually between five and ten percent. [2,3,4,5,6] Given the data that the national percentage of OC compared with LC is 11% or less, and the national rate of conversion is between five and ten percent, the typical patient undergoing OC is an LC to OC conversion.

Although the gold standard for surgical treatment of gallbladder disease is laparoscopic cholecystectomy, patients with suspected perforation, cancer, very large stones, end stage liver disease, bleeding disorders, and some with morbid obesity are not candidates for laparoscopic cholecystectomy. These patients, who are scheduled for an open procedure,

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[1] Csikesz NG, et al. Surgeon volume metrics in laparoscopic cholecystectomy. Dig Dis Sci. 2010;55(8):2398.
[2] Wiseman JT, et al. Surgical Management of Acute Cholecystitis at a Tertiary Care Center in the Modern Era. Arch Surg. 2010;145(5):439-444.
[3] Lipman JM, et al. Preoperative findings predict conversion from laparoscopic to open cholecystectomy. Surgery. 2007 Oct;142(4):556-63.
[4] Kaafarani HM, et al. Trends, outcomes, and predictors of open and conversion to open cholecystectomy in Veterans Health Administration hospitals. Am J Surg. 2010 Jul;200(1):32-40.
[5] Sakpal SV, et al. Laparoscopic cholecystectomy conversion rates two decades later. JSLS. 2010 Oct-Dec;14(4):476-483.
[6] Fuks D, et al. Acute Cholecystitis: Preoperative CT Can Help the Surgeon Consider Conversion from Laparoscopic to Open Cholecystectomy. Radiology. 2012 Apr;263(1):128-38.

are more complex and require the same physician work as the patients who are converted from LC to OC. However, these patients scheduled for elective open cholecystectomy are in the distinct minority and the most common patients are approached first laparoscopically, and then converted to open, based upon operative findings.

As we noted above, CMS may not have been included on the Research Subcommittee conference call and follow-up E-mails where this information was discussed. Therefore, we request that this information be forwarded to CMS with the RUC recommendations. If you have any questions, please contact Jenny Jackson at jjackson@facs.org or at (202) 672-1506.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:47600 Tracking Number n/a Original Specialty Recommended RVU: **20.00**
Presented Recommended RVU: **20.00**
Global Period: 090 RUC Recommended RVU: **20.00**

CPT Descriptor: Cholecystectomy;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An obese patient presents with right upper quadrant pain and ultrasound-demonstrated cholecystitis. Laparoscopic evaluation reveals a severely inflamed gallbladder and the operation is converted to an open procedure to more safely remove the gallbladder.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possiblity of conversion, with witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Place or supervise placement of Foley catheter. Assist anesthesia team with line placement and induction of anesthesia and intubation. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Laparoscopy is commenced through a small incision. Physiologic changes are monitored. The appropriate trocar and camera are inserted, and the assistants' role to retract and insure adequate video image is reconfirmed. A thorough exploration of the abdominal cavity is undertaken visually prior to placing the other access ports. Additional ports are placed via small skin incisions. The liver is retracted appropriately, and other instruments are used to perform as detailed an exploratory laparoscopy as possible, viewing the small bowel, colon, stomach, spleen, and pelvic viscera. Adhesions between the gallbladder and adjacent duodenum are lysed to allow adequate elevation and lateral traction of the gallbladder. If the gallbladder is distended it is decompressed and the contents aspirated and sent for culture if indicated. Once it is determined that inflammation, aberrant anatomy, bleeding or other factors preclude a safe laparoscopic approach, the procedure is converted to open. All the laparoscopic intruments and ports are removed. A laparotomy incision is made with attention to hemostasis. Once safe entry into the peritoneum is achieved adherent underlying structures, if present are freed as needed. Retractors are placed to maintain adequate exposure. A manual and

visual exploration of the upper abdomen is carried out with the objective of inspecting the liver, gallbladder, pancreas, stomach, duodenum, and adjacent colon. Adhesions among these organs are sharply divided and hemostasis ensured. The apex of the fundus of the gallbladder is retracted superiorly. Adhesions to the colon, duodenum, stomach, omentum, and colonic mesentery, if present, are incised with sharp dissection. The infundibulum of the gallbladder is identified in order to expose the Triangle of Calot. Careful dissection in this triangle achieves exposure of the cystic duct which is then dissected from the surrounding tissue and adjacent liver. Care is taken to prevent stones from migrating into the common bile duct. Dissection is carried further to identify and isolate the cystic artery. Utmost care is taken to achieve the critical view of safety before any structure is divided. Careful inspection is undertaken to assess for and delineate aberrant anatomy. At the surgeon's discretion, dissection of the gallbladder may start at the fundus and proceed toward the infundibulum while observing the principles of anatomic identification. Once satisfactory identification of all of these structures has been accomplished, the gallbladder is then dissected from its fossa. The cystic artery is ligated or clipped and transected. The cystic duct is then ligated or clipped at the level of the infundibulum and more proximally, and transected. The gallbladder is removed from the abdomen. It is inspected and opened on the back table to assess pathologic change and to ensure a single ductal system as well as to retrieve stones. Inspection of the fossa for hemostasis is carried out and achieved with either suture or electrocautery. The surgical field, including the areas of adhesiolysis, is also inspected. The entire area of dissection is irrigated with copious amounts of irrigant solution, which is then aspirated. Inspection of the gallbladder fossa and the areas of adhesiolysis is repeated. The cystic artery and cystic duct stumps are inspected to ensure the ligatures are securely in place. At the discretion of the surgeon, a drain may be placed in the subhepatic. A sponge, lap-pad, instrument, and needle count is completed and confirmed to be accurate. The abdominal wound is closed with care to assure hemostasis and elimination of dead space.

Description of Post-Service Work:
Post-operative Work - Hospital: Apply sterile dressings as necessary. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Instruct nursing staff in care of drains, tubes and other devices. Review post-operative labs if required. Discuss procedure and outcome with family. Write postoperative note. Dictate operative report and copy referring physician(s). Call referring physician(s). Patient is discharged from recovery room. Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. Examine patient, including reviewing vital signs and confirming as necessary. Auscultate heart, lungs, and abdomen for bowel sounds. Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection. Continue prophylaxis for DVT. Monitor daily for adequacy. Assess need for beta-blockers, order as required. Assess need for continued antibiotics, order as required. Monitor and document patient progress. Assess pain scores and adequacy of analgesia. Monitor fluid and electrolyte status and renal function. Review nursing/other staff patient chart notes. Write orders for labs (especially liver chemistries, amylase, and lipase) and films (if indicated), medications, diet, and patient activity. Chart patient progress notes daily. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate. Manage drain, if installed, and remove when appropriate. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when taking adequate nutrition and pain control is adequate with oral analgesics. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Post-operative Work - Office: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Christopher Senkowski, MD FACS; Charles Mabry, MD FACS; Don Selzer, MD FACS				
Specialty(s):	general surgery (ACS, SAGES)				
CPT Code:	47600				
Sample Size:	816	**Resp N:**	50	**Response:** 6.1 %	
Description of Sample:	Random selection from ACS and SAGES membership database				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	8.00	50.00
Survey RVW:	14.00	18.00	**20.00**	20.60	23.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	70.00	90.00	**120.00**	120.00	160.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	47600	**Recommended Physician Work RVU: 20.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
44140	090	22.59	**RUC Time**

CPT Descriptor Colectomy, partial; with anastomosis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38100	090	19.55	**RUC Time**	25,612

CPT Descriptor 1 Splenectomy; total (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44140	090	22.59	**RUC Time**	2,749

CPT Descriptor 2 Colectomy, partial; with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 47600**	**Key Reference CPT Code:** 44140	**Source of Time** **RUC Time**
Median Pre-Service Time	70.00	60.00	
Median Intra-Service Time	120.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**475.00**	**480.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.18	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.70
Urgency of medical decision making	4.27	3.30
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.91	3.80
Physical effort required	4.18	3.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.20
Outcome depends on the skill and judgment of physician	4.09	4.30
Estimated risk of malpractice suit with poor outcome	4.00	3.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.55	3.70
Intra-Service intensity/complexity	4.09	4.10
Post-Service intensity/complexity	3.27	3.60

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Codes 47600 and 47605 were identified for review by CMS in the NPRM for 2012. CMS received one public comment regarding a potential relativity problem. In the Rule, CMS states:

We believe that the difference in physician time and visits is the cause for the difference in work RVU for these codes. However, upon clinical review, it does not appear that these visits appropriately reflect the relativity of these two services, as CPT code 47600 should not have more time and visits associated with the service than CPT code 47605. Therefore, we are asking the AMA RUC to review these two cholecystectomy CPT codes, 47600 and 47605.

Compelling Evidence - Change in patient population

In 2005, when 47600 was last reviewed, compelling evidence was presented and accepted regarding advances in technology that have led to a change in medical management (eg, medications) and non-surgical interventions (eg, ERCP) for treating gall bladder disease, resulting in a more complex patient presenting for surgery. The work RVU accepted by the RUC in 2005 was less than the specialty recommendation.

Since 2005, there have been further changes in the clinical picture of the patient who requires an open cholecystectomy. The patient in current practice most typically is a patient who has been converted from a laparoscopic cholecystectomy (LC) to open cholecystectomy (OC). There are many reasons convert from LC to OC, including severity of disease, adhesions from prior abdominal surgery and/or difficulties with defining ductal and other anatomy. As the *rate* of OC compared with LC decreases (significantly), the *percentage* of patients undergoing conversion at operation has increased, such that the typical patient (>50%) is now a patient with an initial LC who due to the technical factors noted above is then converted to an OC. This conversion requires greater intra-service work (complexity and intensity) than is reflected in the current value of 47600.

Pre-time

Pre-time package 4 (Difficult Patient/Difficult Procedure) is recommended, with additional positioning time to account for work related to the initial laparoscopic positioning prior to conversion to an open procedure.

Recommendation

The American College of Surgeons and the Society of American Gastrointestinal and Endoscopic Surgeons conducted a RUC survey for code 47600. The survey data indicate more intra-time and more hospital work.
The current survey data support an increase in the work RVU for 47600 relative to the key reference code, MPC codes, and almost 70 additional inpatient services recently reviewed by the RUC and CMS with work RVUs from 18 to 24.

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST	HVs	OVs
2005	47600	Cholecystectomy;	17.48	0.068	420	60	115	30	4	3
2012	*47600*	*Recommendation*	*20.00*	*0.073*	*475*	*70*	*120*	*30*	*5*	*3*

Key Reference Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST	HVs	OVs
2005	44140	Partial removal of colon	22.59	**0.079**	480	60	150	30	7	3
2012	*47600*	*Recommendation*	*20.00*	*0.073*	*475*	*70*	*120*	*30*	*5*	*3*

MPC Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST	HVs	OVs
2005	**38100**	Removal of spleen total	**19.55**	**0.078**	442	60	120	30	6	2
2012	*47600*	*Recommendation*	***20.00***	***0.073***	*475*	*70*	*120*	*30*	*5*	*3*
2005	**44140**	Partial removal of colon	**22.59**	**0.079**	480	60	150	30	7	3

The current survey data confirm that code 47600 is undervalued. The ACS and SAGES believe there has been a change in the typical patient since 2005 to support compelling evidence for a different work RVU and **we recommend the survey median work RVU of 20.00**.

The table below includes almost 70 codes reviewed by the RUC and CMS with the following parameters: reviewed 2005-2011; work RVUs from 18.00 to 24.00; and inpatient procedure. The codes in this table offer additional support for the recommendation of 20.00 work RVUs for 47600. The recommendation for code 47605 has also been included to show rank order relativity with 47600 and the other codes in the table.

RUC year	CPT	Desc	2012 RVW	IWPUT	Tot time	INTRA	HVs	OVs
2005	**43770**	Lap place gastr adj device	**18.00**	0.108	367	**90**	2	3
2011	**35188**	Repair blood vessel lesion	**18.00**	0.075	380	**150**	3	2
2011	**47564**	Laparo cholecystectomy/explr	**18.00**	0.074	415	**120**	4	3
2005	**33886**	Endovasc prosth delayed	**18.09**	0.100	379	**100**	3	2
2008	**27244**	Treat thigh fracture	**18.18**	0.091	438	**75**	5	4
2008	**27245**	Treat thigh fracture	**18.18**	0.085	443	**80**	5	4
2006	**58544**	Lsh w/t/o uterus above 250 g	**18.37**	0.083	365	**135**	3	3
2007	**23616**	Treat humerus fracture	**18.37**	0.078	413	**120**	3	4
2007	**27558**	Treat knee dislocation	**18.39**	0.069	429	**150**	3	4
2010	**19357**	Breast reconstruction	**18.50**	0.060	468	**110**	2	10
2005	**27465**	Shortening of thigh bone	**18.60**	0.086	384	**120**	4	4
2005	**32651**	Thoracoscopy remove cortex	**18.78**	0.080	502	**70**	7	2
2008	**27269**	Optx thigh fx	**18.89**	0.084	404	**125**	4	4
2007	**27513**	Treatment of thigh fracture	**19.25**	0.067	464	**145**	4	4
2005	**44188**	Lap colostomy	**19.35**	0.103	407	**90**	4	3
2005	**45400**	Laparoscopic proc	**19.44**	0.097	410	**100**	5	3
2005	**34201**	Removal of artery clot	**19.48**	0.079	422	**128**	5	2
2005	**38100**	Removal of spleen total	**19.55**	0.078	442	**120**	6	2
2005	**38101**	Removal of spleen partial	**19.55**	0.078	442	**120**	6	2
2005	**39220**	Resect mediastinal tumor	**19.55**	0.085	436	**124**	4	2
2005	**63075**	Neck spine disk surgery	**19.60**	0.132	355	**90**	2	3
2009	**24152**	Resect radius tumor	**19.99**	0.072	440	**150**	3	4
2012	***47600***	*Removal of gallbladder*	***20.00***	*0.073*	*475*	***120***	*5*	*3*
2007	**58572**	Tlh uterus over 250 g	**20.09**	0.082	400	**150**	3	3
2007	**49203**	Exc abd tum 5 cm or less	**20.13**	0.089	420	**120**	5	3
2009	**27647**	Resect talus/calcaneus tum	**20.26**	0.071	469	**144**	4	3
2009	**24079**	Resect arm/elbow tum 5 cm/>	**20.61**	0.070	472	**150**	4	4
2011	**35840**	Explore abdominal vessels	**20.75**	0.071	491	**120**	6	3
2005	**43771**	Lap revise gastr adj device	**20.79**	0.107	377	**120**	2	3
2012	***47605***	*Removal of gallbladder*	***21.00***	*0.073*	*490*	***135***	*5*	*3*
2005	**33883**	Insert endovasc prosth taa	**21.09**	0.107	404	**120**	3	2
2005	**34471**	Removal of vein clot	**21.11**	0.070	453	**180**	5	3
2011	**32673**	Thoracoscopy w/thymus resect	**21.13**	0.081	447	**150**	4	2
2006	**35302**	Rechanneling of artery	**21.35**	0.096	392	**150**	3	2
2005	**32665**	Thoracoscop w/esoph musc exc	**21.53**	0.087	512	**105**	6	2
2009	**27049**	Resect hip/pelv tum < 5 cm	**21.55**	0.064	496	**180**	4	4
2009	**21558**	Resect neck tum 5 cm/>	**21.58**	0.068	502	**160**	4	4
2009	**22905**	Resect abd tum 5 cm/>	**21.58**	0.078	463	**150**	4	4
2005	**27130**	Total hip arthroplasty	**21.79**	0.081	478	**135**	5	4
2005	**35616**	Artery bypass graft	**21.82**	0.108	367	**140**	3	2
2005	**38115**	Repair of ruptured spleen	**21.88**	0.084	492	**120**	7	2
2005	**38720**	Removal of lymph nodes neck	**21.95**	0.075	482	**150**	4	4
2008	**43279**	Lap myotomy heller	**22.10**	0.097	404	**150**	3	2
2005	**44130**	Bowel to bowel fusion	**22.11**	0.072	516	**131**	8	3
2007	**49657**	Lap inc hern recur comp	**22.11**	0.072	493	**180**	4	3
2009	**25170**	Resect radius/ulnar tumor	**22.21**	0.073	470	**180**	3	4
2005	**35606**	Artery bypass graft	**22.46**	0.097	414	**145**	3	2
2005	**43820**	Fusion of stomach and bowel	**22.53**	0.071	545	**120**	8	3
2009	**21936**	Resect back tum 5 cm/>	**22.55**	0.073	510	**160**	4	4
2009	**23078**	Resect shoulder tum 5 cm/>	**22.55**	0.072	490	**180**	3	4
2005	**44140**	Partial removal of colon	**22.59**	0.079	480	**150**	7	3
2005	**24363**	Replace elbow joint	**22.65**	0.085	466	**150**	4	4
2009	**23200**	Resect clavicle tumor	**22.71**	0.077	497	**155**	4	4

RUC year	CPT	Desc	2012 RVW	IWPUT	Tot time	INTRA	HVs	OVs
2007	**58573**	Tlh w/t/o uterus over 250 g	**23.11**	0.093	415	**165**	3	3
2006	**35883**	Revise graft w/nonauto graft	**23.15**	0.086	462	**170**	4	2
2009	**27646**	Resect fibula tumor	**23.21**	0.067	540	**180**	4	4
2005	**27447**	Total knee arthroplasty	**23.25**	0.099	469	**124**	5	4
2009	**24150**	Resect distal humerus tumor	**23.46**	0.074	502	**180**	4	4
2005	**22612**	Lumbar spine fusion	**23.53**	0.088	482	**150**	4	3
2011	**32669**	Thoracoscopy remove segment	**23.53**	0.084	502	**150**	5	2
2006	**35303**	Rechanneling of artery	**23.60**	0.111	392	**150**	3	2
2006	**35305**	Rechanneling of artery	**23.60**	0.104	402	**160**	3	2
2006	**33254**	Ablate atria lmtd	**23.71**	0.126	416	**120**	3	2
2006	**33265**	Ablate atria lmtd endo	**23.71**	0.100	446	**150**	3	2
2005	**38724**	Removal of lymph nodes neck	**23.95**	0.073	512	**180**	4	4

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 47600

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,084 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database information for 2010

Specialty general surgery Frequency 15283 Percentage 89.45 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 47600

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:47605 Tracking Number

Original Specialty Recommended RVU: **21.00**
Presented Recommended RVU: **21.00**
RUC Recommended RVU: **21.00**

Global Period: 090

CPT Descriptor: Cholecystectomy; with cholangiography

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An obese patient presents with right upper quadrant pain and ultrasound-demonstrated cholecystitis. Laparoscopic evaluation reveals a severely inflamed gallbladder and the operation is converted to an open procedure to more safely remove the gallbladder. Preoperative elevated liver enzymes and the need for anatomic clarity mandate intraoperative cholangiogram.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possiblity of conversion, with witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Place or supervise placement of Foley catheter. Assist anesthesia team with line placement and induction of anesthesia and intubation. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Laparoscopy is commenced through a short small. Physiologic changes are monitored. The appropriate trocar and camera are inserted, and the assistants' role to retract and insure adequate video image is reconfirmed. A thorough exploration of the abdominal cavity is undertaken visually prior to placing the other access ports. Additional ports are placed via small skin incisions. The liver is retracted appropriately, and other instruments are used to perform as detailed an exploratory laparoscopy as possible, viewing the small bowel, colon, stomach, spleen, and pelvic viscera. Adhesions between the gallbladder and adjacent duodenum are lysed to allow adequate elevation and lateral traction of the gallbladder. If the gallbladder is distended it is decompressed and the contents aspirated and sent for culture if indicated. Once it is determined that inflammation, aberrant anatomy, bleeding or other factors preclude a safe laparoscopic approach, the procedure is converted to open. All the laparoscopic intruments and ports are removed. A laparotomy incision is made with attention to hemostasis. Once safe entry into the peritoneum is achieved adherent

underlying structures, if present are freed as needed. Retractors are placed to maintain adequate exposure. A manual and visual exploration of the upper abdomen is carried out with the objective of inspecting the liver, gallbladder, pancreas, stomach, duodenum, and adjacent colon. Adhesions among these organs are sharply divided and hemostasis ensured. The apex of the fundus of the gallbladder is retracted superiorly. Adhesions to the colon, duodenum, stomach, omentum, and colonic mesentery, if present, are incised with sharp dissection. The infundibulum of the gallbladder is identified in order to expose the Triangle of Calot. Dissection continues to achieve exposure of the cystic duct which is then dissected from the surrounding tissue and adjacent liver. Care is taken to prevent stones from migrating into the common bile duct. Dissection is carried further to identify and isolate the cystic artery. Utmost care is taken to achieve the critical view of safety before any structure is divided. When this anatomy is unclear or there are other indications for evaluating the ductal structures, a cholangiogram is performed. A catheter is introduced via the gallbladder or cystic duct and secured in place. The catheter is flushed and then using fluoroscopy or plain x-ray imaging, the cholangiogram is performed. During the acquisition of images, the patient is rotated to the right to avoid superimposing the ducts over the spine and then the patient is moved from Trendelenberg to reverse Trendelenberg to ensure that the ducts within liver are visualized and that the contrast flows into the duodenum. Once the cholangiogram is complete then the catheter is removed. Careful inspection is undertaken to assess for and delineate aberrant anatomy using the images obtained from the cholangiogram to guide surgical strategy. At the surgeon's discretion, dissection of the gallbladder may start at the fundus and proceed toward the infundibulum while observing the principles of anatomic identification. Once satisfactory identification of all of these structures has been accomplished, the gallbladder is then dissected from its fossa. The cystic artery is ligated or clipped and transected. The cystic duct is then ligated or clipped at the level of the infundibulum and more proximally, and transected. The gallbladder is removed from the abdomen. It is inspected and opened on the back table to assess pathologic change and to ensure a single ductal system as well as to retrieve stones. Inspection of the fossa for hemostasis is carried out and achieved with either suture or electrocautery. The surgical field, including the areas of adhesiolysis, is also inspected. The entire area of dissection is irrigated with copious amounts of irrigant solution, which is then aspirated. Inspection of the gallbladder fossa and the areas of adhesiolysis is repeated. The cystic artery and cystic duct stumps are inspected to ensure the ligatures are securely in place. At the discretion of the surgeon, a drain may be placed in the subhepatic. A sponge, lap-pad, instrument, and needle count is completed and confirmed to be accurate. The abdominal wound is closed with care to assure hemostasis and elimination of dead space.

Description of Post-Service Work:
Post-operative Work - Hospital: Apply sterile dressings as necessary. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Instruct nursing staff in care of drains, tubes and other devices. Review post-operative labs if required. Discuss procedure and outcome with family. Write postoperative note. Dictate operative report and copy referring physician(s). Call referring physician(s). Patient is discharged from recovery room. Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. Examine patient, including reviewing vital signs and confirming as necessary. Auscultate heart, lungs, and abdomen for bowel sounds. Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection. Continue prophylaxis for DVT. Monitor daily for adequacy. Assess need for beta-blockers, order as required. Assess need for continued antibiotics, order as required. Monitor and document patient progress. Assess pain scores and adequacy of analgesia. Monitor fluid and electrolyte status and renal function. Review nursing/other staff patient chart notes. Write orders for labs (especially liver chemistries, amylase, and lipase) and films (if indicated), medications, diet, and patient activity. Chart patient progress notes daily. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate. Manage drain, if installed, and remove when appropriate. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when taking adequate nutrition and pain control is adequate with oral analgesics. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Post-operative Work - Office: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Christopher Senkowski, MD FACS; Charles Mabry, MD FACS; Don Selzer, MD FACS				
Specialty(s):	general surgery (ACS, SAGES)				
CPT Code:	47605				
Sample Size:	816	**Resp N:**	50	**Response:** 6.1 %	
Description of Sample:	Random selection from ACS and SAGES membership database				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**4.00**	6.00	35.00
Survey RVW:	15.00	19.66	**21.00**	23.00	25.00
Pre-Service Evaluation Time:			**63.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	90.00	113.00	**135.00**	144.00	195.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	47605	**Recommended Physician Work RVU: 21.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**135.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
44140	090	22.59	**RUC Time**

CPT Descriptor Colectomy, partial; with anastomosis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38100	090	19.55	**RUC Time**	2,749

CPT Descriptor 1 Splenectomy; total (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44140	090	22.59	**RUC Time**	25,612

CPT Descriptor 2 Colectomy, partial; with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 47605**	**Key Reference CPT Code:** 44140	**Source of Time** **RUC Time**
Median Pre-Service Time	70.00	60.00	
Median Intra-Service Time	135.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**490.00**	**480.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.67
Urgency of medical decision making	4.13	3.47
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.40	4.07
Physical effort required	4.40	4.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	4.00
Outcome depends on the skill and judgment of physician	4.33	4.20
Estimated risk of malpractice suit with poor outcome	4.53	3.87

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.60
Intra-Service intensity/complexity	4.40	4.13
Post-Service intensity/complexity	3.47	3.47

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Codes 47600 and 47605 were identified for review by CMS in the NPRM for 2012. CMS received one comment regarding a potential relativity problem. In the Rule, CMS states:

We believe that the difference in physician time and visits is the cause for the difference in work RVU for these codes. However, upon clinical review, it does not appear that these visits appropriately reflect the relativity of these two services, as CPT code 47600 should not have more time and visits associated with the service than CPT code 47605. Therefore, we are asking the AMA RUC to review these two cholecystectomy CPT codes, 47600 and 47605.

Compelling Evidence - Change in patient population

Since **2000**, when 47605 was last reviewed (using a mini-survey), advances in technology have led to a change in medical management (eg, medications) and non-surgical interventions (eg, ERCP) for treating gall bladder disease. This has resulted in a more complex patient presenting for surgery. In addition, similar to the compelling evidence presented in the SoR for CPT 47605, the patient in current practice who undergoes open cholecystectomy is typically a patient that has been converted from a laparoscopic cholecystectomy (LC) to open cholecystectomy (OC). There are many reasons to convert from LC to OC, including severity of disease, adhesions from prior abdominal surgery, difficulties with defining ductal anatomy, and/or failure to perform a cholangiogram laparoscopically to better define ductal anatomy, and conversion to open is chosen as the best and safest alternative. As the *rate* of OC compared with LC decreases (significantly), the *percentage* of patients undergoing conversion at operation has increased, such that the typical patient (>50%) is now an LC to OC conversion. This conversion requires greater intra-service work (time and complexity).

Pre-time

Pre-time package 4 (Difficult Patient/Difficult Procedure) is recommended, with additional positioning time to account for work related to the initial laparoscopic positioning prior to conversion to an open procedure.

Recommendation

The American College of Surgeons and the Society of American Gastrointestinal and Endoscopic Surgeons conducted a full RUC survey for code 47605. The survey data indicate significantly more intra-time, one additional hospital visit, and one additional office visit when compared with the RUC database information from a mini-survey in 2000.

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST	HVs	OVs
2000	47605	Cholecystectomy; w-cholangiogram	15.98	**0.075**	387	75	90	30	4	2
2012	*47605*	*Recommendation*	*21.00*	***0.073***	*490*	*70*	*135*	*30*	*5*	*3*

The current survey data support an increase in the work RVU for 47605 relative to the key reference code and MPC codes.

Key Reference Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST	HVs	OVs
2005	**44140**	Partial removal of colon	**22.59**	**0.079**	480	60	150	30	7	3
2012	***47605***	*Recommendation*	***21.00***	***0.073***	*490*	*70*	*135*	*30*	*5*	*3*

MPC Comparison

RUC Year	CPT	DESC	RVW	IWPUT	Tot Time	PRE	INTRA	POST	HVs	OVs
2005	**38100**	Removal of spleen total	**19.55**	**0.078**	442	60	120	30	6	2
2012	***47605***	*Recommendation*	***21.00***	***0.073***	*490*	*70*	*135*	*30*	*5*	*3*
2005	**44140**	Partial removal of colon	**22.59**	**0.079**	480	60	150	30	7	3

The current survey data confirm that code 47605 is undervalued. The ACS and SAGES believe there has been a significant change in the typical patient and technology since 2000 to support compelling evidence for a different work RVU and **we recommend the survey median work RVU of 21.00**. The incremental difference of 1.00 work RVUs between 47605 and 47600 accounts for the increased intra-operative work (time and complexity) to perform a cholangiogram.

The table below includes almost 70 codes reviewed by the RUC and CMS with the following parameters: reviewed 2005-2011; work RVUs from 18.00 to 24.00; and inpatient procedure. The codes in this table offer additional support for the recommendation of 21.00 work RVUs for 47605. The recommendation for code 47600 has also been included to show rank order relativity with 47605 and the other codes in the table.

RUC year	CPT	Desc	2012 RVW	IWPUT	Tot time	INTRA	HVs	OVs
2005	**43770**	Lap place gastr adj device	**18.00**	0.108	367	**90**	2	3
2011	**35188**	Repair blood vessel lesion	**18.00**	0.075	380	**150**	3	2
2011	**47564**	Laparo cholecystectomy/explr	**18.00**	0.074	415	**120**	4	3
2005	**33886**	Endovasc prosth delayed	**18.09**	0.100	379	**100**	3	2
2008	**27244**	Treat thigh fracture	**18.18**	0.091	438	**75**	5	4
2008	**27245**	Treat thigh fracture	**18.18**	0.085	443	**80**	5	4
2006	**58544**	Lsh w/t/o uterus above 250 g	**18.37**	0.083	365	**135**	3	3
2007	**23616**	Treat humerus fracture	**18.37**	0.078	413	**120**	3	4
2007	**27558**	Treat knee dislocation	**18.39**	0.069	429	**150**	3	4
2010	**19357**	Breast reconstruction	**18.50**	0.060	468	**110**	2	10
2005	**27465**	Shortening of thigh bone	**18.60**	0.086	384	**120**	4	4
2005	**32651**	Thoracoscopy remove cortex	**18.78**	0.080	502	**70**	7	2
2008	**27269**	Optx thigh fx	**18.89**	0.084	404	**125**	4	4
2007	**27513**	Treatment of thigh fracture	**19.25**	0.067	464	**145**	4	4
2005	**44188**	Lap colostomy	**19.35**	0.103	407	**90**	4	3
2005	**45400**	Laparoscopic proc	**19.44**	0.097	410	**100**	5	3
2005	**34201**	Removal of artery clot	**19.48**	0.079	422	**128**	5	2
2005	**38100**	Removal of spleen total	**19.55**	0.078	442	**120**	6	2
2005	**38101**	Removal of spleen partial	**19.55**	0.078	442	**120**	6	2
2005	**39220**	Resect mediastinal tumor	**19.55**	0.085	436	**124**	4	2
2005	**63075**	Neck spine disk surgery	**19.60**	0.132	355	**90**	2	3
2009	**24152**	Resect radius tumor	**19.99**	0.072	440	**150**	3	4
2012	***47600***	*Removal of gallbladder*	***20.00***	*0.073*	*475*	***120***	*5*	*3*
2007	**58572**	Tlh uterus over 250 g	**20.09**	0.082	400	**150**	3	3
2007	**49203**	Exc abd tum 5 cm or less	**20.13**	0.089	420	**120**	5	3
2009	**27647**	Resect talus/calcaneus tum	**20.26**	0.071	469	**144**	4	3
2009	**24079**	Resect arm/elbow tum 5 cm/>	**20.61**	0.070	472	**150**	4	4
2011	**35840**	Explore abdominal vessels	**20.75**	0.071	491	**120**	6	3
2005	**43771**	Lap revise gastr adj device	**20.79**	0.107	377	**120**	2	3
2012	***47605***	*Removal of gallbladder*	***21.00***	*0.073*	*490*	***135***	*5*	*3*
2005	**33883**	Insert endovasc prosth taa	**21.09**	0.107	404	**120**	3	2
2005	**34471**	Removal of vein clot	**21.11**	0.070	453	**180**	5	3
2011	**32673**	Thoracoscopy w/thymus resect	**21.13**	0.081	447	**150**	4	2
2006	**35302**	Rechanneling of artery	**21.35**	0.096	392	**150**	3	2
2005	**32665**	Thoracoscop w/esoph musc exc	**21.53**	0.087	512	**105**	6	2
2009	**27049**	Resect hip/pelv tum < 5 cm	**21.55**	0.064	496	**180**	4	4
2009	**21558**	Resect neck tum 5 cm/>	**21.58**	0.068	502	**160**	4	4
2009	**22905**	Resect abd tum 5 cm/>	**21.58**	0.078	463	**150**	4	4
2005	**27130**	Total hip arthroplasty	**21.79**	0.081	478	**135**	5	4
2005	**35616**	Artery bypass graft	**21.82**	0.108	367	**140**	3	2
2005	**38115**	Repair of ruptured spleen	**21.88**	0.084	492	**120**	7	2
2005	**38720**	Removal of lymph nodes neck	**21.95**	0.075	482	**150**	4	4
2008	**43279**	Lap myotomy heller	**22.10**	0.097	404	**150**	3	2
2005	**44130**	Bowel to bowel fusion	**22.11**	0.072	516	**131**	8	3
2007	**49657**	Lap inc hern recur comp	**22.11**	0.072	493	**180**	4	3
2009	**25170**	Resect radius/ulnar tumor	**22.21**	0.073	470	**180**	3	4
2005	**35606**	Artery bypass graft	**22.46**	0.097	414	**145**	3	2
2005	**43820**	Fusion of stomach and bowel	**22.53**	0.071	545	**120**	8	3
2009	**21936**	Resect back tum 5 cm/>	**22.55**	0.073	510	**160**	4	4
2009	**23078**	Resect shoulder tum 5 cm/>	**22.55**	0.072	490	**180**	3	4
2005	**44140**	Partial removal of colon	**22.59**	0.079	480	**150**	7	3
2005	**24363**	Replace elbow joint	**22.65**	0.085	466	**150**	4	4
2009	**23200**	Resect clavicle tumor	**22.71**	0.077	497	**155**	4	4

RUC year	CPT	Desc	2012 RVW	IWPUT	Tot time	INTRA	HVs	OVs
2007	**58573**	Tlh w/t/o uterus over 250 g	**23.11**	0.093	415	**165**	3	3
2006	**35883**	Revise graft w/nonauto graft	**23.15**	0.086	462	**170**	4	2
2009	**27646**	Resect fibula tumor	**23.21**	0.067	540	**180**	4	4
2005	**27447**	Total knee arthroplasty	**23.25**	0.099	469	**124**	5	4
2009	**24150**	Resect distal humerus tumor	**23.46**	0.074	502	**180**	4	4
2005	**22612**	Lumbar spine fusion	**23.53**	0.088	482	**150**	4	3
2011	**32669**	Thoracoscopy remove segment	**23.53**	0.084	502	**150**	5	2
2006	**35303**	Rechanneling of artery	**23.60**	0.111	392	**150**	3	2
2006	**35305**	Rechanneling of artery	**23.60**	0.104	402	**160**	3	2
2006	**33254**	Ablate atria lmtd	**23.71**	0.126	416	**120**	3	2
2006	**33265**	Ablate atria lmtd endo	**23.71**	0.100	446	**150**	3	2
2005	**38724**	Removal of lymph nodes neck	**23.95**	0.073	512	**180**	4	4

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 47605

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,201
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database information for 2010

Specialty general surgery Frequency 3859 Percentage 91.85 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 47605

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Cholecystectomy

TAB: 36

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	AC-inpt/same da 33	32	31	38	Office 15	14	13	12	11
REF	44140	Colectomy, partial; with anastomos	11	0.079			22.59			480	30	15	15			150			30		1	5	1.0			2	1	
RUC-2005	47600	Cholecystectomy;		0.068			17.48			420	30	15	15			115			30	1	1	1	1.0			2	1	
SVY	47600	Cholecystectomy;	50	0.070	14.00	18.00	20.00	20.60	23.00	490	60	10	15	70	90	120	120	160	30	1	2	1	1.0			2	1	
REC		median		0.073			20.00			475	40	10	20			120			30	1	2	1	1.0			2	1	
REF	44140	Colectomy, partial; with anastomos	15	0.079			22.59			480	30	15	15			150			30		1	5	1.0			2	1	
RUC-2000	47605	Cholecystectomy; with cholangiograp		0.075			15.98			387	75					90			30	1	1	1	1.0			1	1	
SVY	47605	Cholecystectomy; with cholangiograp	50	0.069	15.00	19.66	21.00	23.00	25.00	508	63	10	15	90	113	135	144	195	30	1	2	1	1.0			2	1	
REC		median		0.073			21.00			490	40	10	20			135			30	1	2	1	1.0			2	1	

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

47600	Cholecystectomy;
47605	Cholecystectomy; with cholangiography

Global Period: 090 **Meeting Date:** April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Advisors of ACS and SAGES discussed the current details for 47600 and 47605 which include standard times for pre-service, discharge, and office visits for these facility-only codes.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

The Advisors of ACS and SAGES discussed the current details for 47600 and 47605 and agree that the standard times for pre-service, discharge, and office visits for these facility-only codes are appropriate. Minor adjustments were made to the supplies. Equipment time was modified to reflect changes in the number of office visits for 47605. These are facility only codes, therefore no inputs are recommended for the non-facility category.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global pre-time (60 minutes) as indicated on PE spreadsheet.

Service Clinical Labor Activities:

Standard inpatient discharge (12 minutes) as indicated on PE spreadsheet.

Post-Service Clinical Labor Activities:

Standard office visit post-time (per office visit) as indicated on PE spreadsheet.

	A	B	C	D	E	F	G	H	I	J	K	L
1	REVISED 4-26-12			REFERENCE CODE CMS database		RECOMMEND		REFERENCE CODE CMS database		RECOMMEND		
2				47600		47600		47605		47605		
3	**Meeting Date: April 2012** **Tab: 36** **Specialty: ACS, SAGES**	**CMS Code**	**Staff Type**	Cholecystectomy;		Cholecystectomy;		Cholecystectomy; with cholangiography		Cholecystectomy; with cholangiography		**NOTES**
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	
5	**GLOBAL PERIOD**			**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**n/a**	**171**	**n/a**	**171**	**n/a**	**135**	**n/a**	**171**	
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0**	**60**	**0**	**60**	**0**	**60**	**0**	**60**	
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0**	**12**	**0**	**12**	**0**	**12**	**0**	**12**	
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0**	**99**	**0**	**99**	**0**	**63**	**0**	**99**	
10	**PRE-SERVICE**											
11	**Start: Following visit when decision for surgery or procedure made**											
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		**5**		**5**		**5**		**5**	standard
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		**20**		**20**		**20**		**20**	standard
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**8**		**8**		**8**		**8**	standard
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		**20**		**20**		**20**		**20**	standard
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		**7**		**7**		**7**		**7**	standard
18	**End: When patient enters office/facility for surgery/procedure**											
19	**SERVICE PERIOD**											
20	**Start: When patient enters office/facility for surgery/procedure:**											
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	standard
42	**End: Patient leaves office/facility**											
43	**POST-SERVICE Period**											
44	**Start: Patient leaves office/facility**											
46	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	
47	99211 16 minutes		16									
48	99212 27 minutes		27		**1**		**1**		**1**		**1**	standard
49	99213 36 minutes		36		**2**		**2**		**1**		**2**	standard
50	99214 53 minutes		53									
51	99215 63 minutes		63									
52	**Total Office Visit Time**	*L037D*	RN/LPN/MTA	**0**	**99**	**0**	**99**	**0**	**63**	**0**	**99**	
53	Other Clinical Activity - *specify:*											
54	**End: with last office visit before end of global period**											
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**									
56	pack, minimum multi-specialty visit	SA048	pack		**3**		**3**		**2**		**3**	one for each office visit
57	drape, non-sterile, sheet 40in x 60in	SB006	item		**3**		**3**		**3**		**3**	one for each office visit
58	gloves, sterile	SB024	pair		**3**		**0**		**3**		**0**	included in pack
59	pack, post-op incision care (suture)	SA054	pack		**1**				**1**			switch to suture <u>and</u> staple pack
60	pack, post-op incision care (suture & staple)	SA053	pack				**1**				**1**	at visit for suture and staple removal
61	gauze, sterile 4in x 4in (10 pack uou)	SG056	item		**3**		**1**		**3**		**1**	at visit for suture and staple removal
62	dressing, 5in x 9in (ABD-Combine)	SG039	item		**1**		**1**		**1**		**1**	at visit for suture and staple removal
63	steri-strip (6 strip uou)	SG074	item		**3**		**0**		**3**		**0**	included in pack
64	tape, surgical paper 1in (Micropore)	SG079	inch		**18**		**0**		**18**		**0**	included in pack
65	gown, staff, impervious	SB027	item		**3**				**3**			
66	silver nitrate applicator	SJ046	item		**3**				**3**			
67	**EQUIPMENT**	**CODE**										
68	table, exam	EF023			**99**		**99**		**63**		**99**	
69	light, exam	EQ168			**99**		**99**		**63**		**99**	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes Screen

April 2012

Lithotripsy

In September 2011, CPT Code 50590 *Lithotripsy, extracorporeal shock wave* was identified in the CMS High Expenditure Procedure Codes screen.

The RUC reviewed the survey results from 39 urologists and recommends that the current work RVU of 9.77, which is below the survey 25th percentile, be maintained. The specialty society recommended and the RUC agreed that three office visits (one 99212 and two 99213s) and a half-day discharge management service (99238) accurately describe the post operative physician work to clinically evaluate the patient and order diagnostic tests to reduce the risk of capillary damage, parenchymalor or subcapsular hemorrhage following the procedure. The RUC compared 50590 to key reference service 52648 *Laser vaporization of prostate, including control of postoperative bleeding, complete* (work RVU=12.15) and noted that although intra service times were identical, 52648 is a more intense procedure, with greater total time, compared to the surveyed code. The RUC also compared 50590 to CPT code 29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU=9.67) and determined that physician time and intensity components were analogous and thus the codes should be valued similarly**. The RUC recommends a work RVU of 9.77 for CPT code 50590.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommenda-tion
50590	Lithotripsy, extracorporeal shock wave	090	9.77 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:50590 Tracking Number Original Specialty Recommended RVU: **9.77**
Presented Recommended RVU: **9.77**
Global Period: 090 RUC Recommended RVU: **9.77**

CPT Descriptor: Lithotripsy, extracorporeal shock wave

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 66-year-old man has a 1.5 cm radio-opaque stone in the left renal pelvis which is symptomatic.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 69% , In the ASC 31%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 18%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work:
Pre-Service Work- Day before surgery:
- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be emailed or faxed to hospital)
- Obtain and review all imaging studies

Pre-Service work- Day of surgery:
- Change into scrub clothes.
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Physician sign and explain informed consent in holding area
- Mark “site of surgery”, “side” in holding area
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns (ie., jet ventilator; heart rate, gated or non-gated)
- Transfer patient to lithotriper
- "Time out" for patient identification
- Wait for anesthesiologist to administer general anesthetic
- Put on lead apron, radiation eye protection and insert ear plugs

Description of Intra-Service Work:
- Position patient into shockwave focal point in the X, Y and Z axes

- Check cardiac rate; decide on "gated" or "ungated" treatment plan
- Check visualization of stone on monitors
- Start treatment
- Perform intermittent fluoroscopy to check on stone for movement
- Stop shocks every 100 – 200 shocks to assess stone fragmentation. As stone fragments, reposition patient multiple times to maintain shockwave focal point on stone(s) during treatment
- Adjust intensity of shockwave, gradually increasing intensity levels during treatment
- Conclude treatment when the maximum allowable number of shocks have been delivered
- Place Foley catheter if indicated
- Move patient off lithotripter

Description of Post-Service Work:
Post-service work, same day as procedure through discharge

- Wait for anesthesiologist to awaken patient
- Remove Foley catheter if indicated
- Assist in transfer of patient from lithotriptor to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Review recovery area care and medications with staff
- Discuss procedure with patient as necessary in recovery area when awake
- Conduct post-op pain assessment
- Write any further necessary orders, check pain status
- Dictate operative report
- Call referring physician as necessary
- Meet with family or friend, give pre-printed post op instructions and prescriptions as indicated. (This was also discussed with patient before procedure).

Post-op Office work- After discharge from hospital:

- Examine patient and check for ecchymosis, check vital signs
- Conduct post-op pain assessment
- Check urinalysis
- Check serum creatinine
- KUB X-ray if indicated
- Renal ultrasound if indicated
- Answer questions from patient and family
- Write necessary prescriptions
- Schedule next office visit
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Thomas Cooper, MD; Christopher Gonzalez, MD; Thomas Turk, MD, Martin Dineen, MD		
Specialty(s):	Urology		
CPT Code:	50590		
Sample Size:	134	**Resp N:** 39	**Response:** 29.1 %
Description of Sample:	A random list of 1500-2000 AUA members was pulled. An email was sent to these members to confirm whether or not they performed the procedure in question and if they would be interested in completing a survey. If an affirmative response was received, a survey was sent to the member.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	20.00	**35.00**	50.00	150.00
Survey RVW:	7.00	10.00	**10.90**	12.33	16.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	40.00	45.00	**60.00**	60.00	100.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	50590	**Recommended Physician Work RVU: 9.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
52648	090	12.15	**RUC Time**

CPT Descriptor Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29891	090	9.67	**RUC Time**	478

CPT Descriptor 1 Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54522	090	10.25	**RUC Time**	12,958

CPT Descriptor 2 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
14060	090	9.23	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 23.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 50590**	**Key Reference CPT Code:** 52648	**Source of Time** **RUC Time**
Median Pre-Service Time	51.00	60.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	15.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	

Median Office Visit Time	62.0	69.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**207.00**	**249.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.33	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.00
Urgency of medical decision making	3.33	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.22	3.56
Physical effort required	2.67	3.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.89	3.22
Outcome depends on the skill and judgment of physician	3.78	3.89
Estimated risk of malpractice suit with poor outcome	3.33	3.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.56	3.33
Intra-Service intensity/complexity	3.11	3.56
Post-Service intensity/complexity	3.33	3.22

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AUA expert panel reviewed the survey data and recommended the current work RVU be maintained at 9.77 RVU. The current value of 9.77 is below the 2012 RUC survey 25th percentile of 10.00 and the survey median of 10.90. The technology for performing lithotripsy has not changed, the patient population has not changed, and the procedure time has not changed (as the time is dictated by the technology, which has not changed). The expert panel selected the time package 3 Straightforward patient/difficult procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 50590

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 68024
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation of nationwide utilization is 25% more than Medicare.

Specialty Urology Frequency 67730 Percentage 99.56 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 54,419 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database for 2010.

Specialty Urology Frequency 54180 Percentage 99.56 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 50590

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	32	33	34	35	36
12	**ISSUE:**	**Lithotripsy**																														
13	**TAB:**	**42**																														
14						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**							**Office**				
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
16	**REF**	**52648**	**Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)**		**0.1092**			**12.15**			**249**	**60**					**60**			**60**										**3**		
17	**CURRENT**	**50590**	**Lithotripsy, extracorporeal shock wave**		**0.0802**			**9.77**			**234**	**35**	**15**	**13**			**60**			**30**						**0.5**				**2**	**1**	
18	**SVY**	**50590**	**Lithotripsy, extracorporeal shock wave**	**39**	**0.1144**	**7.00**	**10.00**	**10.90**	**12.33**	**16.00**	**191**	**15**	**10**	**10**	**40**	**45**	**60**	**60**	**100**	**15**						**0.5**				**2**	**1**	
19	**REC**	**50590**	**Lithotripsy, extracorporeal shock wave**		**0.0908**	**9.77**					**207**	**33**	**3**	**15**			**60**			**15**						**0.5**				**2**	**1**	
20																																
21																																
22																																
23																																
24																																
25																																

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: Lithotripsy, extracorporeal shock wave

Global Period: 090 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AUA expert panel consists of ten urologists who represent urological practices, both academic and private settings, from across the United States. They represent the states of Washington, Illinois, New York, Connecticut, Kentucky, Florida and Tennessee. The panel reviews current RUC practice expense information, requests input for supplies and equipment from several urology practices, reviews the information, makes recommendations and submits them to the AMA.

The current RUC Database (2012 v. 1) claims data, Place of Service, states that 98.75% of ESWL is performed in a facility (hospital outpatient, hospital inpatient, ASC, and other hospital sites) and 1.25% is performed in "Physician Office". The AUA is unable to find any practice that performs "in-office" lithotripsy on Medicare patients. The reason for this is that the global fee of $821.67 (physician fee $569.79) leaves a balance of $251.88 which is of course insufficient to cover the cost of lease, rental or ownership of a lithotripter. AUA did find several physician practices in New York State, that do perform "in office" lithotripsy on **non**-Medicare patients; in those cases the physician practice has negotiated a separate contract with a both a company that leases lithotripters and the private insurance company that reimburses for the service. The AUA further notes that since the implementation of the RBRVS Medicare Fee Schedule in January, 1992, we have not received one comment about the in-office global payment for ESWL. Therefore, the AUA has no available data for Practice Expense for "in-office" ESWL.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: We will use the current inputs provided by the 2012 RUC database for CPT code 50590 to develop new practice expense inputs for supplies and equipment.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms

Coordinate pre-surgery services

Schedule space and equipment in facility

Provide pre-service education/obtain consent

Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Conduct phone calls/call in prescriptions

Provide services when patient returns to office for follow-up

Greets patient

Takes them to exam room and provide gown

Takes vitals

Make sure all records are available for physician

Schedule follow-up visits

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2				CPT Code 50590		CPT Code 50590	
3	**Meeting Date: April 2012** **Tab: 42** **Specialty: Urology**	**CMS Code**	**Staff Type**	Lithotripsy, extracorporeal shock wave		Lithotripsy, extracorporeal shock wave	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD : 090**						
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**218.0**	**165.0**	**223.0**	**168.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**35.0**	**60.0**	**35.0**	**60.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**84.0**	**6.0**	**86.0**	**6.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**99.0**	**99.0**	**102.0**	**102.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**10**	**20**	**10**	**20**
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**8**		**8**
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**10**	**20**	**10**	**20**
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**10**	**7**	**10**	**7**
17	Other Clinical Activity - *specify:*						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Review charts	L037D	RN/LPN/MTA	**2**			
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	**3**		**3**	
23	Obtain vital signs	L037D	RN/LPN/MTA	**5**		**5**	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**3**		**2**	
26	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**5**		**2**	
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**52**		**60**	
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**3**	
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**5**		**3**	
34	Clean Scope	L037D	RN/LPN/MTA				
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	**3**		**3**	
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**5**		**5**	
39	Other Clinical Activity - *specify:*						
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**	**6**	**n/a**	**6**
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
43	**End: Patient leaves office**						
44	**POST-SERVICE Period**						
45	**Start: Patient leaves office/facility**						
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			**3**	**3**
47	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
48	99211 16 minutes		16				
49	99212 27 minutes		27	**1**	**1**	**1**	**1**
50	99213 36 minutes		36	**2**	**2**	**2**	**2**
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	**Total Office Visit Time**			**99.0**	**99.0**	**99.0**	**99.0**
54	Other Clinical Activity - *specify:*						
55	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2				CPT Code 50590		CPT Code 50590	
3	**Meeting Date: April 2012** **Tab: 42** **Specialty: Urology**	**CMS Code**	**Staff Type**	Lithotripsy, extracorporeal shock wave		Lithotripsy, extracorporeal shock wave	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD : 090**						
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
57	Pack, minimum multi-specialty visit	SA048	pack	**3**	**3**	**4**	**3**
58							
59							
60							
61							
62	**EQUIPMENT**	**CODE**					
63	table, power	EF031		**1**	**1**	**99**	**99**
64	Light, exam	EQ168		**1**	**1**	**99**	**99**
65	Lithotriptor with C-arm (ESWL)	EQ175		**1**		**86**	
66	room, Radiographic/Fluoroscopic	EL014		**1**		**86**	
67							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes Screen

April 2012

Transurethral Destruction of Prostate Tissue

In September 2011, CPT Code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* was identified in the CMS High Expenditure Procedure Codes screen.

The RUC reviewed the survey results from 33 urologists and recommends that the current work RVU of 10.08 should be maintained. The RUC noted that while the surveyed intra service time of 60 minutes is a reduction from current intra service time of 90 minutes, the post operative visits have increased from two 99213 visits currently assigned to this code to four visits, per the survey data. The RUC noted that there has been a change in technology which now delivers the therapy at a higher temperature putting patients more at risk for clots. The RUC agreed that the increased intensity due to new technology and patients who are more at risk for clots following the procedure does warrant an increase in post operative visits; however, they determined that one 99212, two 99213s and one 99214 visits were more appropriate compared to the survey results.

To justify the current value, the RUC wanted to ensure the reduction in intra-service time was equal to the increase in post operative visits warranted by the change in patient population. The RUC calculated the difference between the current and surveyed intra service time (30 minutes) and multiplied by the current IWPUT (.0643), resulting in a work RVU of 1.93. The current post operative visits include 1.94 work RVUs (two 99213s). The RUC recommended post operative visits result in a work RVU of 3.92. The difference between the current and recommended post operative visits is a work RVU of 1.98. Therefore, the RUC noted that the difference between intra service time and post operative visits was roughly the same. To further support this value, the RUC reviewed CPT code 45190 *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU=10.42, pre-80, intra-60, post-45) and determined that these two services require the same intra-service time of 60 minutes and are similar in work. The RUC also reviewed codes 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU=10.83, pre-60, intra-58, post-45) and 52647 (work RVU=11.30, pre-60, intra-45, post-45) and determined that the intra service times and work are similar. **Therefore, the RUC recommends a work RVU of 10.08 for CPT code 53850.**

Practice Expense:
The Practice Expense Subcommittee understood that previously 2/3 of physician time was allocated to assist physician in performing the procedure. However, the new technology delivers higher intensity/temperature and now requires the nurse to assist 100% of the time.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	090	10.08 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:53850 Tracking Number Original Specialty Recommended RVU: **10.08**
Presented Recommended RVU: **10.08**
Global Period: 090 RUC Recommended RVU: **10.08**

CPT Descriptor: Transurethral destruction of prostate tissue; by microwave thermotherapy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male, suffering from mild to moderate prostatic obstruction. Responded insufficiently to watchful waiting and medical therapies, such as alpha blockers and 5 alpha reductase inhibitors. Patient seeks alternative to more invasive surgical prostatic procedures.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 9%, In the office 91%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 15%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 39%

Description of Pre-Service Work:
Pre-Service Work- Day before surgery

• Review pre-op lab results
•Review medical record
•Obtain and review all imaging studies

Pre-Service work- Day of surgery

•Change into scrub clothes.
•Review surgical procedure, post-op recovery with patient and family
•Answer patient and family questions, be sure informed consent is in record
•Review prostate ultrasound report for prostate size and urethral length;
•If prostate ultrasound has not been performed prior to procedure do at this time to measure urethral length and prostate volume
•Using transrectal ultrasound perform a prostate anesthetic block with lidocaine
•Position patient on procedure table in supine position
•Insert urethral catheter and drain bladder
•Fill bladder with 60 cc of Lidocaine/Marcaine mixture
•Remove catheter
•After catheter is removed inject urethra with 10 cc of 2% xylocaine jelly and place penis clamp
•Wait 10 minutes for local anesthetic to take effect

•Put patient in frog leg position
•Insert thermo-sensing probe thermometer into rectum
•Insert TUMT treatment catheter and inflate balloon
•Perform Limited Ultrasound to check balloon position

Description of Intra-Service Work:
•Start microwave device
•Calibration – Physician chooses protocol and Control Unit begins a 5-step calibration that last 4 to 6 minutes.
•Ramp Up –3 to 7 minutes.
•Treatment Begins – Depending on particular brand of device treatment lasts from 30 to 45 minutes
•Check treatment catheter balloon position every 10 minutes with ultrasound
•Cool-down Phase – Upon completion of treatment the physician begins a 5 minute cool-down of the urethral temperature.
•Remove rectal probe
•Remove treatment catheter

Description of Post-Service Work:

•Place Foley catheter for patient to wear home
•Print-out the data sheet documenting the procedure
•Move patient off of treatment table
•Discuss post op care with patient and family or friend
•Review printed instructions
•Write prescriptions if necessary

Post-op Office visit work-

•Return to office in 3 to 7 days for catheter removal
•Discuss voiding trial results
•Discuss urinalysis results
•Set up follow-up office visits at 4, 8 and 12 weeks

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Thomas Cooper, MD; Christopher Gonzalez, MD; Thomas Turk, MD; Martin Dineen, MD		
Specialty(s):	Urology		
CPT Code:	53850		
Sample Size:	77	**Resp N:** 33	**Response:** 42.8 %
Description of Sample:	A random list of 1500-2000 AUA members was pulled. An email was sent to these members to confirm whether or not they performed the procedure in question and if they would be interested in completing a survey. If an affirmative response was received, a survey was sent to the member.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	20.00	75.00
Survey RVW:	4.30	10.50	**11.00**	12.50	32.06
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	40.00	45.00	**60.00**	60.00	75.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**119.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **2.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	53850	**Recommended Physician Work RVU: 10.08**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**0.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**0.00**	**15.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
53852	090	10.83	**RUC Time**

CPT Descriptor Transurethral destruction of prostate tissue; by radiofrequency thermotherapy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
15100	090	9.90	**RUC Time**	18,105

CPT Descriptor 1 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
15240	090	10.41	**RUC Time**	12,958

CPT Descriptor 2 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 63.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 53850**	**Key Reference CPT Code:** 53852	**Source of Time** **RUC Time**
Median Pre-Service Time	27.00	60.00	
Median Intra-Service Time	60.00	58.00	
Median Immediate Post-service Time	15.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**204.00**	**232.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.81
Urgency of medical decision making	2.86	2.90
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.38	3.86
Physical effort required	2.95	3.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.29	3.48
Outcome depends on the skill and judgment of physician	3.86	3.95
Estimated risk of malpractice suit with poor outcome	3.33	3.24

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.19
Intra-Service intensity/complexity	3.67	3.48
Post-Service intensity/complexity	3.24	3.19

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AUA recommends that this procedure retain the current work RVU of 10.08, which is below the survey median of 11.00 and the 25th percentile of 10.50. Since 2006, this procedure has decreased by over 50% from its highest utilization of 34,994 to the 2010 utilization of 15,222. Although there is no peer reviewed literature on this topic, it is recognized in the urologic community that this procedure is now most commonly performed on patients who are poor candidates for anesthesia and anticipated difficulty with post-anesthesia care. These patients are typically in urinary retention and must have an indwelling Foley catheter due to their benign prostatic hyperplasia. In addition, this procedure is also used to treat patients who are on warfarin, and other anticoagulants, as the drug does not need to be stopped to have the procedure performed. This procedure is performed to allow the patient to become catheter free. This unique patient sub-population has more surgical co-morbidities since introduction of the procedure. Of note, the intra-service time for this procedure has decreased from 90 minutes to 60 minutes according to survey respondents, however, the patient population as noted has self-selected to a more difficult and challenging group of patients to manage.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 53850

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 19027
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. We believe that this procedure is performed nationwide approximately 25% more in the commercial and Medicare market combined.

Specialty Urology Frequency 18856 Percentage 99.10 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,222 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From the RUC database for 2010

Specialty Urology Frequency 15086 Percentage 99.10 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 53850

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	32	33	34	35	36
3	**INSTRUCTIONS**																															
4	**Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.**																															
5	**Hide columns and rows that do not contain data.**																															
6	**REF = Key Reference code data**																															
7	**CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.**																															
8	**SVY = Survey data - as it appears on the Summary of Recommendation form.**																															
9	**REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.**																															
10																																
11																																
12	**ISSUE:**	**Transurethral Destruction of Prostate Tissue**																															
13	**TAB:**	**43**																														
14						**RVW**						**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**								**Office**			
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**	**15**	**14**	**13**	**12**	**11**
16	**REF**	**53852**	**Transurethral destruction of prostate tissue; by radiofrequency thermotherapy**		**0.0960**			**10.83**			**232**	**60**					**58**			**45**										**3**		
17	**CURRENT**	**53850**	**Transurethral destruction of prostate tissue; by microwave thermotherapy**		**0.0643**			**10.08**			**241**	**60**					**90**			**45**										**2**		
18	**SVY**	**53850**	**Transurethral destruction of prostate tissue; by microwave thermotherapy**	**33**	**0.0929**	**4.30**	**10.50**	**11.00**	**12.50**	**32.06**	**229**	**15**	**10**	**10**	**40**	**45**	**60**	**60**	**75**	**15**								**2**	**1**	**1**	
19	**REC**	**53850**	**Transurethral destruction of prostate tissue; by microwave thermotherapy**		**0.0906**	**10.08**					**204**	**7**	**5**	**15**			**60**			**15**								**1**	**2**	**1**	

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: Transurethral destruction of prostate tissue; by microwave thermotherapy

Global Period: 090 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AUA expert panel consists of ten urologists who represent urological practices, both academic and private settings, from across the United States. They represent the states of Washington, Illinois, New York, Connecticut, Kentucky, Florida and Tennessee. The panel reviews current RUC practice expense information, requests input for supplies and equipment from several urology practices, reviews the information, makes recommendations and submits them to the AMA.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: We are using the practice expense spreadsheet from the current RUC database for 53850 TUMT.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Chart is reviewed by clinical staff to verify that correct procedure is ordered for the patient.
- Room is prepared and exam table is covered with paper.
- Patient is greeted and a gown is provided.
- Patient education and consent is obtained.
- Review with patient each step of the treatment and answer patient questions.
- Obtain vitals
- Set up the equipment (microwave unit and ultrasound machine) and sets up the supplies needed for the procedure.
- Assist the physician with positioning and padding of patient in the supine position.
- Assist the physician with the preparation and draping of the patient.
- Assist the physician with the local anesthesia prior to the procedure.

Service Clinical Labor Activities:

- Performs a time-out with physician to make sure proper procedure and proper patient is being treated.

- Clinical staff person hands supplies and equipment to the physician during procedure.
- Assist the physician with repositioning patient after procedure.

Post-Service Clinical Labor Activities:

- Clean the room and disinfect microwave unit.

- Provide follow up information to patient.
- Discuss any adverse reaction at insertion site.
- Confers with the MD verbally for any last minute instructions for patient.
- Next appointment is set up for patient while checking out.

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	**Revised**			**CPT Code 53850**		**CPT Code 53850**	
3	**Meeting Date: April 2012** **Tab: 43** **Specialty: Urology**	**CMS Code**	**Staff Type**	Transurethral destruction of prostate tissue; by microwave thermotherapy		Transurethral destruction of prostate tissue; by microwave thermotherapy	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD: 090**			**90**	**90**		
6	**TOTAL CLINICAL LABOR TIME**			**190.0**	**132.0**	**275.0**	**218.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**35.0**	**60.0**	**35.0**	**60.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**83.0**	**0.0**	**88.0**	**6.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**72.0**	**72.0**	**152.0**	**152.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**10**	**20**	**10**	**20**
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**8**		**8**
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**10**	**20**	**10**	**20**
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**10**	**7**	**10**	**7**
17	Other Clinical Activity - *specify:*						
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Review charts	L037D	RN/LPN/MTA	**2**			
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	**3**		**3**	
23	Obtain vital signs	L037D	RN/LPN/MTA	**3**		**3**	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
25	Prepare room, supplies	L037D	RN/LPN/MTA	**3**		**4**	
26	Setup ultrasound probe	L037D	RN/LPN/MTA			**0**	
27	Setup TUMT machine					**0**	
28	Prepare and position patient/ monitor patient	L037D	RN/LPN/MTA	**3**		**2**	
29	**Intra-service**						
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**60**		**60**	
31	**Post-Service**						
32	Monitor pt. following service/check monitors,catheter/checks vitals	L037D	RN/LPN/MTA	**3**		**5**	
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**	
34	Clean TUMT machine	L037D	RN/LPN/MTA			**0**	
35	Clean ultrasound probe	L037D	RN/LPN/MTA			**3**	
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	**2**		**2**	
37	Review/read X-ray, lab, and pathology reports						
38	Home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**		**3**	
39	Other Clinical Activity - *specify:*						
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	**6**
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
43	**End: Patient leaves office**						
44	**POST-SERVICE Period**						
45	**Start: Patient leaves office/facility**						
46	Conduct phone calls/call in prescriptions						
47	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
48	99211 16 minutes		16				
49	99212 27 minutes		27			**1**	**1**
50	99213 36 minutes		36	**2**	**2**	**2**	**2**
51	99214 53 minutes		53			**1**	**1**
52	99215 63 minutes		63				
53	**Total Office Visit Time**			**72.0**	**72.0**	**152.0**	**152.0**
54	Other Clinical Activity - *specify:*						
55	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	**Revised**			**CPT Code 53850**		**CPT Code 53850**	
3	**Meeting Date: April 2012** **Tab: 43** **Specialty: Urology**	**CMS Code**	**Staff Type**	Transurethral destruction of prostate tissue; by microwave thermotherapy		Transurethral destruction of prostate tissue; by microwave thermotherapy	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD: 090**			**90**	**90**		
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
57	pack, minimum multi-specialty visit	SA048	pack	**3**	**2**	**5**	**4**
58	Stop cock, three way	SC049	item	**1**		**1**	
59	Cystopak(Drapes)	SA045	item	**1**			
60	Cup, urine sterile	SL157	item	**1**		**1**	
61	Foley catheter	SD024	item	**1**		**1**	
62	Drainage bag	SJ031	item	**1**		**1**	
63	Cysto tubing 78"	SD129	item	**1**		**1**	
64	water, sterile for irrigation (250-1000 ml uou)	SH074	item	**4**		**4**	
65	Ascepto bulb syringe	SJ011	item	**1**			
66	underpad, 2ft x 3ft (Chux)	SB044	item	**2**		**2**	
67	Surgical mask with shield	SB034	item	**1**		**1**	
68	Gown, staff, impervious, disposable	SB027	item	**2**		**2**	
69	Surgical cap	SB001	item	**2**			
70	Shoe covers	SB039	item	**2**		**2**	
71	Drape, sterile for Mayo stand	SB012	item	**1**		**1**	
72	Drape-sleeve, sterile (4in x 8ft)	SB017	item	**1**		**1**	
73	Lidocaine 1-2% inj (Xylocaine)	SH047	ml			**30**	
74	Bupivacaine 0.25 % inj (Marcaine)	SH021	ml			**30**	
75	Lidocaine 1-2% inj (Xylocaine)	SH047	ml	**30**		**30**	
76	Lidocaine 1-2% inj (Xylocaine) (Urojet) *(see invoice)		item			**1**	
77	needle, 18-27 gauge	SC029	item	**2**		**2**	
78	Syringe, 10cc or 12 cc	SC051	item	**3**		**2**	
79	Syringe, Toomey	SC062	item			**1**	
80	lubricating jelly (K-Y) (5 gm uou)	SJ032	item	**6**		**6**	
81	gloves, sterile	SB024	pair			**3**	
82	gloves, non-sterile	SB022	pair			**3**	
83	Tape (1-inch)	SG079	item	**1**		**6**	
84	Praktis catheter treatment kit, disposable			**1**			
85	tray, catheter insertion	SA063	tray	**1**		**1**	
86	kit, transurethral microwave thermotherapy	SA036	kit			**1**	
87	drape-towel sterile 18inX26 in	SB019	item			**4**	
88	rectal probe *(see invoice)		Item			**1**	
89	cover-condom, transducer or ultrasound probe	SB005	item	**1**		**2**	
90	sanitzing cloth-wipe (surface, instruments, equipment)	SM022	item			**4**	
91	disinfectant, surface (Environcide, Sanizide)	SM013	oz			**2**	
92	towel paper (Bounty) (per sheet)	SK082	item			**4**	
93	**EQUIPMENT**	**CODE**					
94	table, power	EF031		**1**	**1**	**169**	**169**
95	Light, exam	EQ168		**1**	**1**	**169**	**169**
96	stretcher, endoscopy	EF020		**1**		**99**	
97	Ultrasound unit	EQ250		**1**		**99**	
98	TUMT device *(see invoice)	EQ037		**1**		**99**	
99	mobile back table with wheels	EF027				**99**	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Re-Review Families of New/Revised Codes Screen

April 2012

CT Angiography-PE Only

These services were most recently identified in the Nov. 28, 2011 Final Rule for 2012. CMS requested that the RUC re-review specific codes in a family of CT angiography services that were recently reviewed and bundled. In January 2012, the RUC reviewed the CMS identified family of services and recommended that CPT codes 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* and 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* be referred to the PE Subcommittee to review in April 2012 to determine if any practice expense anomalies exist between the new bundled code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* and these individual codes. The RUC determined that review of physician work is not necessary at this time. The PE Subcommittee reviewed the practice expense inputs and noted that the expert panel overestimated the clinical staff time needed for the CT tech to *Assist the physician in performing procedure/computer post processing,* recommending 57 minutes rather than the 33 minutes needed for the same input for 74174. Practice expense inputs were revised to align with the 30 minutes of physician work intraservice time typical for the family of codes. An additional clinical staff time of 3 minutes was added for computer post processing, resulting in a total of 33 minutes for *Assist the physician in performing procedure/computer post processing*. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
72191		Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing (Do not report 72191 in conjunction with 73706 or 75635. For CTA aorto-iliofemoral runoff, use 75635) (Do not report 72191 in conjunction with 74175. For a combined computed tomographic angiography abdomen and pelvis study, use 74174)	XXX	1.81 (PE Input Recommendations Only)
74175		Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing (Do not report 74175 in conjunction with 73706 or 75635. For CTA aorto-iliofemoral runoff, use 75635) (Do not report 74175 in conjunction with 72191. For a combined computed tomographic angiography abdomen and pelvis study, use 74174)	XXX	1.90 (PE Input Recommendations Only)

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CPT Code: 74175 and 72191
Specialty Society('s) ACR

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
74175 - Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing

72191 - Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Global Period: XXX Meeting Date: 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology convened a consensus panel to finalize the practice expense data for CPT codes 72191 and 74175.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Since both 72191 and 74175 are existing PEAC reviewed codes, and our expert panel felt no change in practice had occurred in the interim, we used the RUC-approved data as the basis for the practice expense inputs. For 2012, a new bundled code for CTA of the abdomen and pelvis was created. Accordingly, we included the inputs 74174 (*Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*) and 74178 (*Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions*), and 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation*) since 74178 and 76377 were used as the building blocks for 74174 at the February 2011 RUC meeting.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Education/instruction/counseling/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Acquire images
- Assist physician in performing procedure/ Computer post processing
- Clean room/equipment by physician staff
- Process films, hang films and review study with interpreting MD prior to patient discharge

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	J
1									
2				76377	76377	74178	74178	7417XX	74174
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **RUC Approved April 2005**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **CMS Refined**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **RUC Approved February 2010**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **CMS Refined**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Revised at Feb 2011 RUC**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**
4	**LOCATION**			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**	L046A	CT Tech	38.0	38.0	90.0	90.0	128.0	122.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L046A	CT Tech	0.0	0.0	7.0	7.0	7.0	7.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L046A	CT Tech	38.0	38.0	83.0	83.0	121.0	115.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			0.0	0.0	0.0	0.0	0.0	0.0
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - *specify:*								
18	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information*	L041B	RT			**7**		**7**	
19	**End: When patient enters office/facility for surgery/procedure**								
20	**SERVICE PERIOD**								
21	**Start: When patient enters office/facility for surgery/procedure:**								
22	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	RT			**3**		**3**	
23	Education/instruction/counseling/obtain consent	L041B	RT			**3**		**3**	
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L041B	RT			**4**		**4**	
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT			**5**		**5**	
29	Sedate/apply anesthesia								
30	**Intra-service**								
31	Acquire images	L041B	RT			**45**		**45**	
32	Starting IV for high volume and rate power injection								
33	Assist physician in performing procedure/ Computer post processing	L046A	CT Tech	**33**				**33**	
34	**Post-Service**								
35	Monitor pt. following service/check tubes, monitors, drains								
36	Clean room/equipment by physician staff	L041B	RT			**3**		**3**	
37	Clean Scope								
38	Clean Surgical Instrument Package								
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	Other Clinical Activity - *specify:*								
43	*Process films, hang films and review study with interpreting MD prior to patient discharge*	L046A	CT Tech	**5**		**20**		**25**	
47	**End: Patient leaves office**								
48	**POST-SERVICE Period**								
49	**Start: Patient leaves office/facility**								
58	Other Clinical Activity - *specify: Review films for adequacy*	L046A	CT Tech						
59	**End: with last office visit before end of global period**								
60	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
61	swab-pad, alcohol	SJ053	item			**1**	**1**	**1**	**1**
62	angiocatheter set	SC002	item			**1**	**1**	**1**	**1**
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	**1**	**1**	**1**
64	povidone swabsticks (3 pack uou)	SJ043	item			**1**	**1**	**1**	**1**
65	computer media, optical disk 2.6gb	SK016	item			**1**		**1**	**1**
66	drape, sterile, three-quarter sheet	SB014	item			**1**	**1**	**1**	**1**
67	iv tubing (extension)	SC019	foot			**1**	**1**	**1**	**3**
68	film, x-ray 14in x 17in	SK034	item	**8**	**8**			**8**	**8**
69	film, x-ray, laser print	SK098	item			**23**	**23**	**23**	**23**
70	x-ray envelope	SK091	item			**1**		**1**	
71	x-ray developer solution	SK089	oz	**8**	**8**			**8**	**8**
72	x-ray fixer solution	SK092	oz	**8**	**8**			**8**	**8**
73	gauze, sterile 2in x 2in	SG053	item			**1**	**1**	**1**	**1**
74	gauze, non-sterile 2in x 2in	SG050	item			**1**	**1**	**1**	**1**
75	gloves, non-sterile	SB022	pair			**1**	**1**	**1**	**1**
76	heparin lock	SC012	item			**1**	**1**	**1**	**1**
77	kit, iv starter	SA019	kit			**1**	**1**	**1**	**1**
78	needle, 14-20g, biopsy	SC025	item			**1**	**1**	**1**	

	A	B	C	D	E	F	G	H	J
1									
2				76377	76377	74178	74178	7417XX	74174
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **RUC Approved April 2005**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **CMS Refined**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **RUC Approved February 2010**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **CMS Refined**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Revised at Feb 2011 RUC**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**
4	**LOCATION**			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX
79	gown, patient	SB026	item			1	1	1	1
80	sodium chloride 0.9% flush syringe	SH065	item			15	15	15	15
81	syringe 20ml	SC053	item			1	1	1	
82	paper, exam table	SB036	foot			7	7	7	7
83	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	SG075	item			6	6	6	6
84	Y-set connection tubing	SD260	item					1	
85	tube, extension (cm)	SC019	foot					76	
86	syringe, pressure (radiology)	SC060	item						1
87	tubing, sterile, connecting (fluid administration)	SD212	item						1
88	stop cock, 4-way	SC050	item						1
89	needle, 18-27g	SC029	item						1
90	syringe, 25ml (MRI power injector)	SC059	item				1		
91	contrast		ml						
92	contrast syringe 200 cc		item						
93	cotton ball		item						
94	D5W		item						
95	gloves, sterile		pair						
96	saline		cc						
97	**EQUIPMENT**	**CODE**							
98	computer workstation, 3D reconstruction CT-MR	ED014		1	38			38	20
99	room, CT	EL007				X	57	82	57
100	film alternator (motorized film viewbox)	ER029		1	9	X	57	82	20
101	film processor, dry, laser	ED024		1				82	20
102	printer, laser, paper	ED032				X	20	10	10
103	Power Injector	ER079							
104	Film Processor, wet	ED025			9				
105	CT Scanner								

	A	B	C	K	L	M	N	O	P
1						April 2012			April 2012
2				741XX	74175	74175	721XX	72191	72191
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image postprocessing** **RUC Approved February 2001**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**	**Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing** **RUC Approved February 2001**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**
4	**LOCATION**			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**	L046A	CT Tech	122.0	98.0	103.0	122.0	60.0	106.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L046A	CT Tech	5.0	5.0	5.0	5.0	0.0	5.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L046A	CT Tech	112.0	93.0	98.0	112.0	60.0	101.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			5.0	0.0	0.0	5.0	0.0	0.0
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - *specify:*								
18	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information*	L041B	RT	5		5	5		5
19	**End: When patient enters office/facility for surgery/procedure**								
20	**SERVICE PERIOD**								
21	**Start: When patient enters office/facility for surgery/procedure:**								
22	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	RT	3		3	3		3
23	Education/instruction/counseling/obtain consent	L041B	RT	2		2	2		2
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L041B	RT	5		2	5		5
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	7		7	7		7
29	Sedate/apply anesthesia								
30	**Intra-service**								
31	Acquire images	L041B	RT	28		28	28		28
32	Starting IV for high volume and rate power injection			5			5		
33	Assist physician in performing procedure/ Computer post processing	L046A	CT Tech	57		33	57		33
34	**Post-Service**								
35	Monitor pt. following service/check tubes, monitors, drains								
36	Clean room/equipment by physician staff	L041B	RT	5		3	5		3
37	Clean Scope								
38	Clean Surgical Instrument Package								
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	Other Clinical Activity - *specify:*								
43	*Process films, hang films and review study with interpreting MD prior to patient discharge*	L046A	CT Tech			20			20
47	**End: Patient leaves office**								
48	**POST-SERVICE Period**								
49	**Start: Patient leaves office/facility**								
58	Other Clinical Activity - *specify: Review films for adequacy*	L046A	CT Tech	5			5		
59	**End: with last office visit before end of global period**								
60	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
61	swab-pad, alcohol	SJ053	item	1	1	1	1	1	1
62	angiocatheter set	SC002	item	1	1	1	1	1	1
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	1	1	1	1	1	1
64	povidone swabsticks (3 pack uou)	SJ043	item		1	1		1	1
65	computer media, optical disk 2.6gb	SK016	item	1	1	0.1	1	1	0.1
66	drape, sterile, three-quarter sheet	SB014	item		1	1		1	1
67	iv tubing (extension)	SC019	foot		3	3		3	3
68	film, x-ray 14in x 17in	SK034	item	12	8	8	12	8	8
69	film, x-ray, laser print	SK098	item		11	11		11	11
70	x-ray envelope	SK091	item	1			1		
71	x-ray developer solution	SK089	oz		8	8		8	8
72	x-ray fixer solution	SK092	oz		8	8		8	8
73	gauze, sterile 2in x 2in	SG053	item		1	1		1	1
74	gauze, non-sterile 2in x 2in	SG050	item		1	1		1	1
75	gloves, non-sterile	SB022	pair		1	1		1	1
76	heparin lock	SC012	item		1	1		1	1
77	kit, iv starter	SA019	kit		1	1		1	1
78	needle, 14-20g, biopsy	SC025	item						

	A	B	C	K	L	M	N	O	P
1						April 2012			April 2012
2				741XX	74175	74175	721XX	72191	72191
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image postprocessing** **RUC Approved February 2001**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**	**Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing** **RUC Approved February 2001**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
79	gown, patient	SB026	item	**1**	**1**	**1**	**1**	**1**	**1**
80	sodium chloride 0.9% flush syringe	SH065	item		**15**	**15**		**15**	**15**
81	syringe 20ml	SC053	item						
82	paper, exam table	SB036	foot		**7**	**7**		**7**	**7**
83	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	SG075	item	**6**	**6**	**6**	**6**	**6**	**6**
84	Y-set connection tubing	SD260	item						
85	tube, extension (cm)	SC019	foot	**76**		**3**	**76**		**3**
86	syringe, pressure (radiology)	SC060	item		**1**	**1**		**1**	**1**
87	tubing, sterile, connecting (fluid administration)	SD212	item	**1**	**1**	**1**	**1**	**1**	**1**
88	stop cock, 4-way	SC050	item	**1**	**1**	**1**	**1**	**1**	**1**
89	needle, 18-27g	SC029	item	**1**	**1**	**1**	**1**	**1**	**1**
90	syringe, 25ml (MRI power injector)	SC059	item			**1**			**1**
91	contrast		ml	**150**			**150**		
92	contrast syringe 200 cc		item	**1**			**1**		
93	cotton ball		item	**1**			**1**		
94	D5W		item	**250cc**			**250cc**		
95	gloves, sterile		pair	**1**			**1**		
96	saline		cc	**10**			**10**		
97	**EQUIPMENT**	**CODE**							
98	computer workstation, 3D reconstruction CT-MR	ED014		**45**	**15**	**33**	**45**	**15**	**33**
99	room, CT	EL007			**40**	**40**		**40**	**40**
100	film alternator (motorized film viewbox)	ER029			**15**	**15**		**15**	**15**
101	film processor, dry, laser	ED024			**15**	**15**		**15**	**15**
102	printer, laser, paper	ED032			**10**	**10**		**10**	**10**
103	Power Injector	ER079		**45**			**45**		
104	Film Processor, wet	ED025							
105	CT Scanner			**45**			**45**		

	A	B	C	D	E	F	G	H	J
1									
2				76377	76377	74178	74178	7417XX	74174
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **RUC Approved April 2005**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **CMS Refined**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **RUC Approved February 2010**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **CMS Refined**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Revised at Feb 2011 RUC**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**
4	**LOCATION**			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**	L046A	CT Tech	38.0	38.0	90.0	90.0	128.0	122.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L046A	CT Tech	0.0	0.0	7.0	7.0	7.0	7.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L046A	CT Tech	38.0	38.0	83.0	83.0	121.0	115.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			0.0	0.0	0.0	0.0	0.0	0.0
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - *specify:*								
18	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information*	L046A	CT Tech			**7**		**7**	
19	**End: When patient enters office/facility for surgery/procedure**								
20	**SERVICE PERIOD**								
21	**Start: When patient enters office/facility for surgery/procedure:**								
22	Greet patient, provide gowning, ensure appropriate medical records are available	L046A	CT Tech			**3**		**3**	
23	Education/instruction/counseling/obtain consent	L046A	CT Tech			**3**		**3**	
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L046A	CT Tech			**4**		**4**	
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L046A	CT Tech			**5**		**5**	
29	Sedate/apply anesthesia								
30	**Intra-service**								
31	Acquire images	L046A	CT Tech			**45**		**45**	
32	Starting IV for high volume and rate power injection								
33	Assist physician in performing procedure/ Computer post processing	L046A	CT Tech	**33**				**33**	
34	**Post-Service**								
35	Monitor pt. following service/check tubes, monitors, drains								
36	Clean room/equipment by physician staff	L046A	CT Tech			**3**		**3**	
37	Clean Scope								
38	Clean Surgical Instrument Package								
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	Other Clinical Activity - *specify:*								
43	*Process films, hang films and review study with interpreting MD prior to patient discharge*	L046A	CT Tech	**5**		**20**		**25**	
47	**End: Patient leaves office**								
48	**POST-SERVICE Period**								
49	**Start: Patient leaves office/facility**								
58	Other Clinical Activity - *specify: Review films for adequacy*	L046A	CT Tech						
59	**End: with last office visit before end of global period**								
60	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
61	swab-pad, alcohol	SJ053	item			**1**	**1**	**1**	**1**
62	angiocatheter set	SC002	item			**1**	**1**	**1**	**1**
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			**1**	**1**	**1**	**1**
64	povidone swabsticks (3 pack uou)	SJ043	item			**1**	**1**	**1**	**1**
65	computer media, optical disk 2.6gb	SK016	item			**1**		**1**	**1**
66	drape, sterile, three-quarter sheet	SB014	item			**1**	**1**	**1**	**1**
67	iv tubing (extension)	SC019	foot			**1**	**1**	**1**	**3**
68	film, x-ray 14in x 17in	SK034	item	**8**	**8**			**8**	**8**
69	film, x-ray, laser print	SK098	item			**23**	**23**	**23**	**23**
70	x-ray envelope	SK091	item			**1**		**1**	
71	x-ray developer solution	SK089	oz	**8**	**8**			**8**	**8**
72	x-ray fixer solution	SK092	oz	**8**	**8**			**8**	**8**
73	gauze, sterile 2in x 2in	SG053	item			**1**	**1**	**1**	**1**
74	gauze, non-sterile 2in x 2in	SG050	item			**1**	**1**	**1**	**1**
75	gloves, non-sterile	SB022	pair			**1**	**1**	**1**	**1**
76	heparin lock	SC012	item			**1**	**1**	**1**	**1**
77	kit, iv starter	SA019	kit			**1**	**1**	**1**	**1**
78	needle, 14-20g, biopsy	SC025	item			**1**	**1**	**1**	

	A	B	C	D	E	F	G	H	J
1									
2				76377	76377	74178	74178	7417XX	74174
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **RUC Approved April 2005**	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.** **CMS Refined**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **RUC Approved February 2010**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.** **CMS Refined**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Revised at Feb 2011 RUC**	**Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**
4	**LOCATION**			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX
79	gown, patient	SB026	item			1	1	1	1
80	sodium chloride 0.9% flush syringe	SH065	item			15	15	15	15
81	syringe 20ml	SC053	item			1	1	1	
82	paper, exam table	SB036	foot			7	7	7	7
83	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	SG075	item			6	6	6	6
84	Y-set connection tubing	SD260	item					1	
85	tube, extension (cm)	SC019	foot					76	
86	syringe, pressure (radiology)	SC060	item						1
87	tubing, sterile, connecting (fluid administration)	SD212	item						1
88	stop cock, 4-way	SC050	item						1
89	needle, 18-27g	SC029	item						1
90	syringe, 25ml (MRI power injector)	SC059	item				1		
91	contrast		ml						
92	contrast syringe 200 cc		item						
93	cotton ball		item						
94	D5W		item						
95	gloves, sterile		pair						
96	saline		cc						
97	**EQUIPMENT**	**CODE**							
98	computer workstation, 3D reconstruction CT-MR	ED014		1	38			38	20
99	room, CT	EL007				X	57	82	57
100	film alternator (motorized film viewbox)	ER029		1	9	X	57	82	20
101	film processor, dry, laser	ED024		1				82	20
102	printer, laser, paper	ED032				X	20	10	10
103	Power Injector	ER079							
104	Film Processor, wet	ED025			9				
105	CT Scanner								

	A	B	C	K	L	M	N	O	P
1						April 2012			April 2012
2				741XX	74175	74175	721XX	72191	72191
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image postprocessing** **RUC Approved February 2001**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**	**Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing** **RUC Approved February 2001**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**
4	**LOCATION**			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**	L046A	CT Tech	122.0	98.0	106.0	122.0	60.0	106.0
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L046A	CT Tech	5.0	5.0	5.0	5.0	0.0	5.0
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L046A	CT Tech	112.0	93.0	101.0	112.0	60.0	101.0
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			5.0	0.0	0.0	5.0	0.0	0.0
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - *specify:*								
18	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information*	L046A	CT Tech	**5**		**5**	**5**		**5**
19	**End: When patient enters office/facility for surgery/procedure**								
20	**SERVICE PERIOD**								
21	**Start: When patient enters office/facility for surgery/procedure:**								
22	Greet patient, provide gowning, ensure appropriate medical records are available	L046A	CT Tech	**3**		**3**	**3**		**3**
23	Education/instruction/counseling/obtain consent	L046A	CT Tech	**2**		**2**	**2**		**2**
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L046A	CT Tech	**5**		**5**	**5**		**5**
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L046A	CT Tech	**7**		**7**	**7**		**7**
29	Sedate/apply anesthesia								
30	**Intra-service**								
31	Acquire images	L046A	CT Tech	**28**		**28**	**28**		**28**
32	Starting IV for high volume and rate power injection			**5**			**5**		
33	Assist physician in performing procedure/ Computer post processing	L046A	CT Tech	**57**		**33**	**57**		**33**
34	**Post-Service**								
35	Monitor pt. following service/check tubes, monitors, drains								
36	Clean room/equipment by physician staff	L046A	CT Tech	**5**		**3**	**5**		**3**
37	Clean Scope								
38	Clean Surgical Instrument Package								
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	Other Clinical Activity - *specify:*								
43	*Process films, hang films and review study with interpreting MD prior to patient discharge*	L046A	CT Tech			**20**			**20**
47	**End: Patient leaves office**								
48	**POST-SERVICE Period**								
49	**Start: Patient leaves office/facility**								
58	Other Clinical Activity - *specify: Review films for adequacy*	L046A	CT Tech	**5**			**5**		
59	**End: with last office visit before end of global period**								
60	**MEDICAL SUPPLIES**	**CODE**	**UNIT**						
61	swab-pad, alcohol	SJ053	item	**1**	**1**	**1**	**1**	**1**	**1**
62	angiocatheter set	SC002	item	**1**	**1**	**1**	**1**	**1**	**1**
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**	**1**	**1**	**1**	**1**	**1**
64	povidone swabsticks (3 pack uou)	SJ043	item		**1**	**1**		**1**	**1**
65	computer media, optical disk 2.6gb	SK016	item	**1**	**1**	**1**	**1**	**1**	**1**
66	drape, sterile, three-quarter sheet	SB014	item		**1**	**1**		**1**	**1**
67	iv tubing (extension)	SC019	foot		**3**	**3**		**3**	**3**
68	film, x-ray 14in x 17in	SK034	item	**12**	**8**	**8**	**12**	**8**	**8**
69	film, x-ray, laser print	SK098	item		**11**	**11**		**11**	**11**
70	x-ray envelope	SK091	item	**1**			**1**		
71	x-ray developer solution	SK089	oz		**8**	**8**		**8**	**8**
72	x-ray fixer solution	SK092	oz		**8**	**8**		**8**	**8**
73	gauze, sterile 2in x 2in	SG053	item		**1**	**1**		**1**	**1**
74	gauze, non-sterile 2in x 2in	SG050	item		**1**	**1**		**1**	**1**
75	gloves, non-sterile	SB022	pair		**1**	**1**		**1**	**1**
76	heparin lock	SC012	item		**1**	**1**		**1**	**1**
77	kit, iv starter	SA019	kit		**1**	**1**		**1**	**1**
78	needle, 14-20g, biopsy	SC025	item						

	A	B	C	K	L	M	N	O	P
1						April 2012			April 2012
2				741XX	74175	74175	721XX	72191	72191
3	**Meeting Date: April 2012** **Tab: 49** **Specialty: ACR**	**CMS Code**	**Staff Type**	**Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image postprocessing** **RUC Approved February 2001**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**	**Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing** **RUC Approved February 2001**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **CMS Refined**	**Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **RUC April 2012**
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
79	gown, patient	SB026	item	**1**	**1**	**1**	**1**	**1**	**1**
80	sodium chloride 0.9% flush syringe	SH065	item		**15**	**15**		**15**	**15**
81	syringe 20ml	SC053	item						
82	paper, exam table	SB036	foot		**7**	**7**		**7**	**7**
83	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	SG075	item	**6**	**6**	**6**	**6**	**6**	**6**
84	Y-set connection tubing	SD260	item						
85	tube, extension (cm)	SC019	foot	**76**		**3**	**76**		**3**
86	syringe, pressure (radiology)	SC060	item		**1**	**1**		**1**	**1**
87	tubing, sterile, connecting (fluid administration)	SD212	item	**1**	**1**	**1**	**1**	**1**	**1**
88	stop cock, 4-way	SC050	item	**1**	**1**	**1**	**1**	**1**	**1**
89	needle, 18-27g	SC029	item	**1**	**1**	**1**	**1**	**1**	**1**
90	syringe, 25ml (MRI power injector)	SC059	item			**1**			**1**
91	contrast		ml	**150**			**150**		
92	contrast syringe 200 cc		item	**1**			**1**		
93	cotton ball		item	**1**			**1**		
94	D5W		item	**250cc**			**250cc**		
95	gloves, sterile		pair	**1**			**1**		
96	saline		cc	**10**			**10**		
97	**EQUIPMENT**	**CODE**							
98	computer workstation, 3D reconstruction CT-MR	ED014		**45**	**15**	**33**	**45**	**15**	**33**
99	room, CT	EL007			**40**	**101**		**40**	**101**
100	film alternator (motorized film viewbox)	ER029			**15**	**15**		**15**	**15**
101	film processor, dry, laser	ED024			**15**	**15**		**15**	**15**
102	printer, laser, paper	ED032			**10**	**10**		**10**	**10**
103	Power Injector	ER079		**45**			**45**		
104	Film Processor, wet	ED025							
105	CT Scanner			**45**			**45**		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other-Utilization over 500,000 Screen

April 2012

CT Abdomen

In February 2008, CPT Code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* was identified in the CMS/Other-Utilization over 500,000 screen.

The RUC reviewed the survey results from 75 radiologists and recommends that the current work RVU of 1.40, which is below the survey 25th percentile, be maintained. The RUC noted that in April 2010, three codes were created to report the combination of computed tomography of the abdomen and pelvis. As a result, Medicare utilization has significantly decreased from 859,320 in 2010 to 145,235 in 2011 for code 74170. The RUC reviewed key reference service 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU=2.10) and agreed that although intensity components are similar, 74178 requires 12 more minutes of intra-service time and should be valued higher. The RUC compared 74170 to 73718 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)* (work RVU=1.35) and determined that these two services require the same physician work and time and therefore should be valued similarly. The RUC also agreed that a work RVU of 1.40 will maintain proper rank order within the family of CT codes, including 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU=1.27) and 74150 *Computed tomography, abdomen; without contrast material* (work RVU=1.19). **The RUC recommends a work RVU of 1.40 for CPT Code 74170.**

Practice Expense:
The RUC reviewed and approved practice expense inputs as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections (For a combined CPT abdomen and pelvis study, see 74176-74178) (To report 3D rendering, see 76376, 76377) (For computed tomographic colonography, diagnostic, see 74261-74262. For computer tomographic colonography, screening, use 74263) (Do not report 74150-74170 in conjunction with 74261-74263)	XXX	1.40 (No Change)

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AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes

April 2012

Transvaginal and Transrectal Ultrasound

In September 2011, CPT Codes 76830 *Ultrasound, transvaginal* and 76872 *Ultrasound, transrectal* were identified in the CMS High Expenditure Procedure Codes screen.

76830 *Ultrasound, transvaginal*
The RUC reviewed the survey results from 120 radiologists and obstetricians/gynecologists and recommends that the current work RVU of 0.69, which is below the survey 25th percentile, be maintained for CPT Code 76830. The RUC noted that 76830 is billed with 76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete* and determined that there is no overlap of physician work when the services are performed on the same date of service. The RUC reviewed physician time and recommends the survey median times of 5 minutes of pre-time, 10 minutes of intra-service time and 10 minutes of post-time. The RUC noted that post-service time increased from 5 minutes in 2005 to 10 minutes in this survey and agreed that since there is an increased rate of sepsis following the procedure, there should be more time allocated for patient discussion. The RUC compared 76830 to the key reference code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU=0.75 and intra-time=10 minutes) and determined that the urgency of medical decision making and risk of malpractice with poor outcomes is greater in 76817 compared to the surveyed code. Thus, the reference code should be valued higher. The RUC also reviewed 20600 *Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)* (work RVU=0.66 pre-11, intra-5 and post-5) and determined that these two services require similar intensity and total time. Finally, to further justify a work RVU of 0.69, the RUC reviewed CPT Code 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU=0.71, pre-5, intra-5, post-5) and agreed that the overall work is similar. **The RUC recommends a work RVU of 0.69 for CPT Code 76830.**

76872 *Ultrasound, transrectal*
The RUC reviewed the results of 69 radiologists and urologists and recommends that the current work RVU of 0.69 be maintained, which is below the survey 25th percentile for CPT Code 76872. The RUC noted that although 76872 is also billed with 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* and 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision*, this procedure is typically not used for cancer, but rather to determine therapy to relieve patients of primary bladder neck obstruction. Therefore, there is no duplication of physician work when these services are reported on the same day. The RUC reviewed CPT Code 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU=0.63) and agreed that 76872 requires 10 more minutes and should be valued higher. In addition, the RUC reviewed 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU=0.81) and determined that although 76700 requires less time, it is a more intense procedure and should be valued higher

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than the surveyed code. A work RVU of 0.69 maintains proper rank within this family of services. **The RUC recommends a work RVU of 0.69 for CPT Code 76872.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
76830	Ultrasound, transvaginal (For obstetrical transvaginal ultrasound, use 76817) (If transvaginal examination is done in addition to transabdominal non-obstetrical ultrasound exam, use 76830 in addition to appropriate transabdominal exam code)	XXX	0.69 (No Change)
76872	Ultrasound, transrectal (Do not report 76872 in conjunction with 0249T)	XXX	0.69 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76830 Tracking Number Original Specialty Recommended RVU: **0.69**
Presented Recommended RVU: **0.69**
Global Period: XXX RUC Recommended RVU: **0.69**

CPT Descriptor: Ultrasound, transvaginal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old woman was diagnosed with a complex right ovarian cyst six weeks ago by trans-abdominal pelvic ultrasound. The lesion was presumed to represent a benign hemorrhagic cyst. After six weeks the patient has a persisting right adenexal mass on physical examination. A transvaginal examination ultrasound of the pelvis is ordered for further evaluation and characterization.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable imaging studies.

Description of Intra-Service Work:
- Supervise the sonographer performing the exam.
- Interpret the ultrasound exam, which may include evaluation of the following structures:
  - Uterus including evaluation of the endometrium
  - Ovaries
  - Cul de sac
  - Parametrium
- Compare the exam and correlate the findings to previous studies.
- Dictate report for the medical record.

Description of Post-Service Work:
- Discuss and explain findings with patient
- Review and sign final report.
- Discuss findings with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Geraldine McGinty, MD; Zeke Silva, MD; George Hill, MD		
Specialty(s):	American College of Radiology and the American Congress of Obstetricians and Gynecologists		
CPT Code:	76830		
Sample Size:	3602	**Resp N:** 120	**Response:** 3.3 %
Description of Sample:	A survey was sent to 400 randomly selected ACR and ACOG members as well as AIUM members who selected gynecology as their specialty.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	58.00	**150.00**	400.00	4000.00
Survey RVW:	0.50	0.80	**0.98**	1.18	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**10.00**	15.00	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	76830	**Recommended Physician Work RVU: 0.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76817	XXX	0.75	**RUC Time**

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, transvaginal

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20600	000	0.66	**RUC Time**	396,910

CPT Descriptor 1 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
65205	000	0.71	**RUC Time**	34,470

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival superficial

Other Reference CPT Code	Global	Work RVU	Time Source
76813	XXX	1.18	**RUC Time**

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 30 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 76830**	**Key Reference CPT Code:** 76817	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	10.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**25.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.17	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.03	2.67
Urgency of medical decision making	3.00	3.30
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.47	3.33
Physical effort required	2.43	2.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.63	2.57
Outcome depends on the skill and judgment of physician	3.70	3.47
Estimated risk of malpractice suit with poor outcome	3.53	3.90

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.07	2.00
Intra-Service intensity/complexity	3.37	3.07
Post-Service intensity/complexity	2.73	2.43

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76830

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Obstetrics/Gynecology How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1371576
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 76830 provided nationally in a one-year period is estimated to be 1,371,576.

Specialty Obstetrics/Gynecology Frequency 818282 Percentage 59.65 %

Specialty Diagnostic Radiology Frequency 448643 Percentage 32.71 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 457,192 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that CPT code 76830 will be billed approximately 457,192 times for Medicare patients nationally in a one-year period.

Specialty Obstetrics/Gynecology Frequency 272761 Percentage 59.66 %

Specialty Diagnostic Radiology Frequency 149548 Percentage 32.71 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 76830

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76872 Tracking Number Original Specialty Recommended RVU: **0.69**
Presented Recommended RVU: **0.69**
Global Period: XXX RUC Recommended RVU: **0.69**

CPT Descriptor: Ultrasound, transrectal;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74 year old man with voiding difficulty not responsive to alpha blockers or 5-alpha reductase inhibitors and a PSA of 0.8 is being evaluated for possible invasive or minimally-invasive prostate surgery. Transrectal prostate ultrasound is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 14%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work:
- Obtain and review pertinent records and previous history, laboratory studies
- Check ultrasound equipment
- Explain procedure to patient again
- Position patient on his left side with knees flexed

Description of Intra-Service Work:
- Perform digital rectal exam before inserting probe
- Gently insert transrectal ultrasound probe into rectum
- Allow one minute for anal sphincter to accommodate to probe
- Adjust ultrasound image controls to size of prostate
- Using coronal image, measure prostate height and width
- Using sagittal image measure prostatic urethral length
- Freeze image to calculate prostate volume from previous measurements
- Note presence or absence of hypoechoic areas
- Note presence or absence of prostatic calcifications
- Note presence or absence of prostatic cysts
- Note presence or absence of prostate median lobe
- If median prostate lobe present, note size
- Evaluate seminal vesicles
- Print image on thermal paper or transfer image to PACS

Description of Post-Service Work:

- Explain findings to patient
- Dictate diagnostic findings report
- Complete facility or non-facility paperwork

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Thomas P. Cooper, M.D., Martin Dineen, M.D., Christopher Gonzalez, M.D., Thomas Turk, M.D., Geraldine McGinty, M.D., Zeke Silva, M.D.		
Specialty(s):	American Urological Association/American College of Radiology		
CPT Code:	76872		
Sample Size:	1040	**Resp N:** 69	**Response:** 6.6 %
Description of Sample:	A survey was sent to 114 randomly selected AUA members with 64 responses and 926 randomly selected ACR members with 5 responses. The results were combined and recommendations made based on combined data.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	25.00	**50.00**	100.00	350.00
Survey RVW:	0.49	0.81	**1.30**	1.55	3.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	76872	**Recommended Physician Work RVU: 0.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76873	XXX	1.55	**RUC Time**

CPT Descriptor Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93307	XXX	0.92	**RUC Time**	93,293

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 40 **% of respondents:** 57.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 76872**	**Key Reference CPT Code:** 76873	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	20.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**35.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	3.48
Urgency of medical decision making	3.08	3.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.93	3.93
Physical effort required	3.18	3.23
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.93	3.03
Outcome depends on the skill and judgment of physician	3.78	3.78
Estimated risk of malpractice suit with poor outcome	3.10	3.28

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.05	3.18
Intra-Service intensity/complexity	3.65	3.73
Post-Service intensity/complexity	3.18	3.40

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76872

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty Diagnostic Radiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 327402
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 25% more of these procedures are performed nationwide.

Specialty Urology Frequency 306320 Percentage 93.56 %

Specialty Diagnostic Radiology Frequency 7405 Percentage 2.26 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 261,922 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that CPT code 76872 was billed approximately 261,922 times for Medicare patients nationally in a one-year period.

Specialty Urology Frequency 245060 Percentage 93.56 %

Specialty Diagnostic Radiology Frequency 5925 Percentage 2.26 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 76872

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Transvaginal Ultrasound

TAB: 44

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	76817	Ultrasound, pregnant uteru	30	0.046			0.75			23	5					10			8
CURRENT	76830	Ultrasound, transvaginal		0.043			0.69			20	3					12			5
SVY	76830	Ultrasound, transvaginal	120	0.064	0.50	0.80	0.98	1.18	3.00	25	5			3	10	10	15	45	10
REC	76830	Ultrasound, transvaginal		0.033			0.69			25	5					12			8

SS Rec Summary

ISSUE: Transrectal Ultrasound

TAB: 44

American Urological Association/American College of Radiology - Combined Survey Results

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	40	0.029			1.55			60	20					30			10
CURRENT	76872	Ultrasound, transrectal;					0.69			20									
SVY	76872	Ultrasound, transrectal;	69	0.057	0.49	0.81	1.30	1.55	3.00	35	10			5	10	15	20	45	10
REC	76872	Ultrasound, transrectal;		0.016			0.69			35	10					15			10

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: Ultrasound, transvaginal;

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACOG and ACR convened a consensus panel to review and finalize the practice expense data for code 76830.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Since 76830 is an existing code, we used the PEAC approved data as the basis for the practice expense inputs for code 76830.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior images for comparison

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure/ acquire images
- Clean room/equipment by physician staff
- Process images, complete data sheet, present images and data to the interpreting physician

Post-Service Clinical Labor Activities:

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: Ultrasound, transrectal;

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AUA and ACR convened a consensus panel to review and finalize the practice expense data for code 76872.

One important change comes from the report of the Ultrasound Workgroup at the January 2012 RUC meeting. Currently, 76872 includes an ultrasound room (EL015) and related equipment (ED024, ER029). This was changed to an Ultrasound, portable (EQ250).

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: Since 76872 is a current code, the information on the PE spreadsheet will be compared to the existing clinical staff, staff time, supplies, and equipment in the RUC database.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior images for comparison

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient
- Assist physician in performing procedure/acquire images
- Obtain vital signs
- Clean room/equipment by physician staff
- Clean ultrasound probe
- Process images, complete data sheet, present images and data to the interpreting physician

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1	**Tab 44: Revised 04/26/2012**			**76830**		**76830**	
2	**Meeting Date: 04/2012** **Tab: 44** **Specialty: ACOG and ACR**	**CMS Code**	**Staff Type**	**Ultrasound, transvaginal** **(PEAC approved - March 2002)**		**Ultrasound, transvaginal** **(April 2012)**	
3	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**	**L051B**	RN/Diagnostic Medical Sonographer	**40.0**	**0.0**	**42.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**3.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**37.0**	**0.0**	**39.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity - *specify: Retrieve prior images for comparison*	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
17	**End: When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure:**						
20	Greet patient, provide gowning, ensure appropriate medical records are available	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
21	Provide pre-service education/obtain consent						
22	Prepare room, equipment, supplies	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
23	Setup scope						
24	Prepare and position patient/ monitor patient/ set up IV	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
25	**Intra-service**						
26	Assist physician in performing procedure/ acquire images	L051B	RN/Diagnostic Medical Sonographer	**20**		**20**	
27	**Post-Service**						
28	Monitor pt. following service/check tubes, monitors, drains						
29	Clean room/equipment by physician staff	L051B	RN/Diagnostic Medical Sonographer	**3**		**2**	
30	Clean ultrasound probe	L051B	RN/Diagnostic Medical Sonographer			**3**	
31	Other Clinical Activity - *specify: Process images, complete data sheet, present images and data to the interpreting physician*	L051B	RN/Diagnostic Medical Sonographer	**5**		**5**	
32	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	
33	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
34	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
35	**End: Patient leaves office**						
36	**POST-SERVICE Period**						
37	**Start: Patient leaves office/facility**						
38	Conduct phone calls/call in prescriptions						
39	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
40	99211 16 minutes		16				
41	99212 27 minutes		27				
42	99213 36 minutes		36				
43	99214 53 minutes		53				
44	99215 63 minutes		63				
45	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
46	Other Clinical Activity - *specify:*						
47	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	**Tab 44: Revised 04/26/2012**			**76830**		**76830**	
2	**Meeting Date: 04/2012** **Tab: 44** **Specialty: ACOG and ACR**	**CMS Code**	**Staff Type**	**Ultrasound, transvaginal** **(PEAC approved - March 2002)**		**Ultrasound, transvaginal** **(April 2012)**	
3	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
48	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
49	film, x-ray 14in x 17in	SK034	item	**3**		**3**	
50	film, 8inx10in (ultrasound, MRI)	SK022	item	**2**		**2**	
51	lubricating jelly (Surgilube)	SJ033	oz	**1**		**1**	
52	cover-condom, transducer or ultrasound probe	SB005	item	**1**		**1**	
53	pillow case	SB037	item	**1**		**1**	
54	disinfectant spray (Transeptic)	SM012	ml	**10**		**10**	
55	'underpad 2ft x 3ft (Chux)	SB044	item	**1**		**1**	
56	'gloves, non-sterile	SB022	pair	**2**		**2**	
57	'x-ray envelope	SK091	item	**1**		**1**	
58	'x-ray developer solution	SK089	item	**1**		**1**	
59	'sanitizing cloth-wipe (patient)	SM021	item	**2**		**2**	
60	lubricating jelly (K-Y) (5gm uou)	SJ032	item	**1**		**1**	
61							
62							
63	**EQUIPMENT**	**CODE**					
64	room, ultrasound, general	EL015		**1**		**45 min**	
65	film processor, dry, laser	ED024				**5 min**	
66	film alternator (motorized film viewbox)	ER029		**1**		**10 min**	
67	Laser printer	ED032		**1**		**15 min**	
68							

	A	B	C	D	E	F	G
1	**Tab 44: Revised 04/26/2012**			**76830**		**76830**	
2	**Meeting Date: 04/2012** **Tab: 44** **Specialty: ACOG and ACR**	**CMS Code**	**Staff Type**	**Ultrasound, transvaginal** **(PEAC approved - March 2002)**		**Ultrasound, transvaginal** **(April 2012)**	
3	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**	**L051B**	RN/Diagnostic Medical Sonographer	**40.0**	**0.0**	**43.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**3.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**37.0**	**0.0**	**40.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity - *specify: Retrieve prior images for comparison*	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
17	**End: When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure:**						
20	Greet patient, provide gowning, ensure appropriate medical records are available	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
21	Provide pre-service education/obtain consent						
22	Prepare room, equipment, supplies	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
23	Setup scope						
24	Prepare and position patient/ monitor patient/ set up IV	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
25	**Intra-service**						
26	Assist physician in performing procedure/ acquire images	L051B	RN/Diagnostic Medical Sonographer	**20**		**20**	
27	**Post-Service**						
28	Monitor pt. following service/check tubes, monitors, drains						
29	Clean room/equipment by physician staff	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
30	Clean ultrasound probe	L051B	RN/Diagnostic Medical Sonographer			**3**	
31	Other Clinical Activity - *specify: Process images, complete data sheet, present images and data to the interpreting physician*	L051B	RN/Diagnostic Medical Sonographer	**5**		**5**	
32	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	
33	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
34	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
35	**End: Patient leaves office**						
36	**POST-SERVICE Period**						
37	**Start: Patient leaves office/facility**						
38	Conduct phone calls/call in prescriptions						
39	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
40	99211 16 minutes		16				
41	99212 27 minutes		27				
42	99213 36 minutes		36				
43	99214 53 minutes		53				
44	99215 63 minutes		63				
45	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
46	Other Clinical Activity - *specify:*						
47	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	**Tab 44: Revised 04/26/2012**			**76830**		**76830**	
2	**Meeting Date: 04/2012** **Tab: 44** **Specialty: ACOG and ACR**	**CMS Code**	**Staff Type**	**Ultrasound, transvaginal** **(PEAC approved - March 2002)**		**Ultrasound, transvaginal** **(April 2012)**	
3	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
48	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
49	film, x-ray 14in x 17in	SK034	item	**3**		**3**	
50	film, 8inx10in (ultrasound, MRI)	SK022	item	**2**		**2**	
51	lubricating jelly (Surgilube)	SJ033	oz	**1**		**1**	
52	cover-condom, transducer or ultrasound probe	SB005	item	**1**		**1**	
53	pillow case	SB037	item	**1**		**1**	
54	disinfectant spray (Transeptic)	SM012	ml	**10**		**10**	
55	'underpad 2ft x 3ft (Chux)	SB044	item	**1**		**1**	
56	'gloves, non-sterile	SB022	pair	**2**		**2**	
57	'x-ray envelope	SK091	item	**1**		**1**	
58	'x-ray developer solution	SK089	item	**1**		**1**	
59	'sanitizing cloth-wipe (patient)	SM021	item	**2**		**2**	
60	lubricating jelly (K-Y) (5gm uou)	SJ032	item	**1**		**1**	
61							
62							
63	**EQUIPMENT**	**CODE**					
64	room, ultrasound, general	EL015		**1**		**45 min**	
65	film processor, dry, laser	ED024				**5 min**	
66	film alternator (motorized film viewbox)	ER029		**1**		**10 min**	
67	Laser printer	ED032		**1**		**15 min**	
68							

	A	B	C	D	E	F	G
1	Revised 4/26/12			REFERENCE CODE			
2				76872		76872	
3	**Meeting Date: April 2012** **Tab: 44** **Specialty: American Urological Association/American College of Radiology**	**CMS Code**	**Staff Type**	Ultrasound, transrectal; **PEAC Approved March 2002**		Ultrasound, transrectal;	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	L051B	RN/Diagnostic Medical Sonographer	**40.0**	**0.0**	**45.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**3.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**37.0**	**0.0**	**42.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Retrieve prior images for comparison*:*	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Review Chart	L051B	RN/Diagnostic Medical Sonographer			**0**	
22	Greet patient, provide gowning, ensure appropriate medical records are available	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
23	Obtain vital signs	L051B	RN/Diagnostic Medical Sonographer			**0**	
24	Provide pre-service education/obtain consent	L051B	RN/Diagnostic Medical Sonographer			**3**	
25	Prepare room, equipment, supplies	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
26	Prepare ultrasound probe					**0**	
27	Prepare and position patient	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
28	**Intra-service**						
29	Assist physician in performing procedure/ Acquire images	L051B	RN/Diagnostic Medical Sonographer	**20**		**20**	
30	**Post-Service**						
31	Obtain vital signs					**0**	
32	Clean room/equipment	L051B	RN/Diagnostic Medical Sonographer	**3**		**2**	
33	Clean ultrasound probe	L051B	RN/Diagnostic Medical Sonographer			**3**	
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Other Clinical Activity - *specify:*						
39	Process images, complete data sheet, present images and data to the interpreting physician	L051B	RN/Diagnostic Medical Sonographer	**5**		**5**	
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
43	**End: Patient leaves office**						
44	**POST-SERVICE Period**						
45	**Start: Patient leaves office/facility**						
46	Conduct phone calls/call in prescriptions						
47	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
54	Other Clinical Activity - *specify:*						
55	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	Revised 4/26/12			REFERENCE CODE			
2				76872		76872	
3	**Meeting Date: April 2012** **Tab: 44** **Specialty: American Urological Association/American College of Radiology**	**CMS Code**	**Staff Type**	Ultrasound, transrectal; **PEAC Approved March 2002**		Ultrasound, transrectal;	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**	
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
57	pack, minimum multi-specialty visit	SA048	pack			**1**	
58	film, x-ray 14in x 17in	SK034	item	**3**			
59	film, 8in x 10in (ultrasound, MRI)	SK022	item	**2**			
60	paper, laser printer (each sheet)	SJ057	item			**1**	
61	lubricating jelly (Surgilube)	SJ033	oz.	**1**		**1**	
62	cover-condom, transducer or ultrasound probe	SB005	item	**1**		**2**	
63	pillow case	SB037	item	**1**			
64	disinfectant spray (Transeptic)	SM012	ml	**10**		**10**	
65	underpad 2ft x 3ft (Chux)	SB044	item	**1**		**1**	
66	gloves, non-sterile	SB022	pair	**2**		**4**	
67	x-ray envelope	SK091	item	**1**		**1**	
68	x-ray developer	SK089	item	**1**			
69	sanitizing cloth-wipe (patient)	SM021	item	**2**		**2**	
70	lubricating jelly (K-Y) (5 gm uou)	SJ032	item	**1**		**2**	
71	drape, nonsterile, sheet 40in x 60in	SB006	item			**1**	
72	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz.			**32**	
73	glutaraldehyde test strip (Cidex, Metrex)	SM019	item			**1**	
74	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			**2**	
75	lidocaine, 2% jelly topical (Xylocaine)	SH048	ml			**10**	
76	alcohol isopropyl 70%	SJ001	ml			**5**	
77	drape, sterile, for Mayo stand	SB012	item			**1**	
78	IV extension tube	SC019	item			**1**	
79	10 cc syringe	SC051	item			**2**	
80	**EQUIPMENT**	**CODE**					
81	room, ultrasound, general	EL015		**37**			
82	film processor, dry, laser	ED024		**5**			
83	film alternator (motorized film)	ER029		**10**			
84							
85	ultrasound unit, portable	EQ250				**68 min**	
86	ultrasound probe (see invoice)	New				**68 min**	
87	ultrasound table	EF034				**68 min**	
88	table, instrument, mobile	EF027				**68 min**	
89	thermal printer (see invoice)	New				**15 min**	

	A	B	C	D	E	F	G
1	Revised 4/26/12			REFERENCE CODE			
2				76872		76872	
3	**Meeting Date: April 2012 Tab: 44 Specialty: American Urological Association/American College of Radiology**	**CMS Code**	**Staff Type**	Ultrasound, transrectal; **PEAC Approved March 2002**		Ultrasound, transrectal;	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	L051B	RN/Diagnostic Medical Sonographer	**40.0**	**0.0**	**56.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**37.0**	**0.0**	**56.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Retrieve prior images for comparison*:*	L051B	RN/Diagnostic Medical Sonographer	**3**			
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Review Chart	L051B	RN/Diagnostic Medical Sonographer			**3**	
22	Greet patient, provide gowning, ensure appropriate medical records are available	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
23	Obtain vital signs	L051B	RN/Diagnostic Medical Sonographer			**3**	
24	Provide pre-service education/obtain consent	L051B	RN/Diagnostic Medical Sonographer			**3**	
25	Prepare room, equipment, supplies	L051B	RN/Diagnostic Medical Sonographer	**3**		**2**	
26	Prepare ultrasound probe					**5**	
27	Prepare and position patient	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
28	**Intra-service**						
29	Assist physician in performing procedure/ Acquire images	L051B	RN/Diagnostic Medical Sonographer	**20**		**20**	
30	**Post-Service**						
31	Obtain vital signs					**3**	
32	Clean room/equipment	L051B	RN/Diagnostic Medical Sonographer	**3**		**3**	
33	Clean ultrasound probe	L051B	RN/Diagnostic Medical Sonographer			**3**	
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Other Clinical Activity - *specify:*						
39	Process images, complete data sheet, present images and data to the interpreting physician	L051B	RN/Diagnostic Medical Sonographer	**5**		**5**	
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**	
43	**End: Patient leaves office**						
44	**POST-SERVICE Period**						
45	**Start: Patient leaves office/facility**						
46	Conduct phone calls/call in prescriptions						
47	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	**Total Office Visit Time**			**0.0**	**0.0**	**0.0**	**0.0**
54	Other Clinical Activity - *specify:*						
55	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	Revised 4/26/12			REFERENCE CODE			
2				76872		76872	
3	**Meeting Date: April 2012** **Tab: 44** **Specialty: American Urological Association/American College of Radiology**	**CMS Code**	**Staff Type**	Ultrasound, transrectal; **PEAC Approved March 2002**		Ultrasound, transrectal;	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**	
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
57	pack, minimum multi-specialty visit	SA048	pack			**1**	
58	film, x-ray 14in x 17in	SK034	item	**3**			
59	film, 8in x 10in (ultrasound, MRI)	SK022	item	**2**			
60	paper, laser printer (each sheet)	SJ057	item			**1**	
61	lubricating jelly (Surgilube)	SJ033	oz.	**1**		**1**	
62	cover-condom, transducer or ultrasound probe	SB005	item	**1**		**2**	
63	pillow case	SB037	item	**1**			
64	disinfectant spray (Transeptic)	SM012	ml	**10**		**10**	
65	underpad 2ft x 3ft (Chux)	SB044	item	**1**		**1**	
66	gloves, non-sterile	SB022	pair	**2**		**4**	
67	x-ray envelope	SK091	item	**1**		**1**	
68	x-ray developer	SK089	item	**1**			
69	sanitizing cloth-wipe (patient)	SM021	item	**2**		**2**	
70	lubricating jelly (K-Y) (5 gm uou)	SJ032	item	**1**		**2**	
71	drape, nonsterile, sheet 40in x 60in	SB006	item			**1**	
72	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz.			**32**	
73	glutaraldehyde test strip (Cidex, Metrex)	SM019	item			**1**	
74	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item			**2**	
75	lidocaine, 2% jelly topical (Xylocaine)	SH048	ml			**10**	
76	alcohol isopropyl 70%	SJ001	ml			**5**	
77	drape, sterile, for Mayo stand	SB012	item			**1**	
78	IV extension tube	SC019	item			**1**	
79	10 cc syringe	SC051	item			**2**	
80	**EQUIPMENT**	**CODE**					
81	room, ultrasound, general	EL015		**37**			
82	film processor, dry, laser	ED024		**5**			
83	film alternator (motorized film)	ER029		**10**			
84							
85	ultrasound unit, portable	EQ250				**68 min**	
86	ultrasound probe (see invoice)	New				**68 min**	
87	ultrasound table	EF034				**68 min**	
88	table, instrument, mobile	EF027				**68 min**	
89	thermal printer (see invoice)	New				**15 min**	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes screen

April 2012

Radiotherapy Dose Plan IMRT

In the July 19, 2011, Proposed Rule for 2012, CMS requested that the RUC review high expenditure services. CPT code 77301 was selected because it had not been reviewed in almost ten years. In September 2011, the Relativity Assessment Workgroup reviewed this service and recommended that the specialty societies submit action plans for January 2012. In January 2012 the RUC recommended that this service be surveyed for physician work and practice expense in April 2012.

77301 ***Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications***
The RUC reviewed the survey results from 90 radiation oncologists and agreed with the specialty society that the survey respondents accurately estimated the physician work involved in this service: intra-service time= 160 minutes and post-service time= 35 minutes. Currently, 77301 has 30 minutes of pre-service time, however, the specialty explained that the three primary work components involved in this service, image acquisition, contouring and dose prescription are all performed in the intra-service time. The survey was modified and approved by the Research Subcommittee to preclude pre-service physician work and add a more robust description of intra-service work. The RUC agreed that this reallocation more accurately apportions the time required to complete this service. Finally, the RUC noted that while this procedure is intensive and completed over several hours, CPT code 77301 is only reported once per course of therapy.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 7.99, just below the survey's 25th percentile, accurately reflects the physician work involved in the service. To justify this value, the RUC compared the surveyed code to key reference service 77435 *Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions* (work RVU= 11.87) and agreed that while the services are fundamentally similar with a high degree of complex planning, imaging evaluation and clinical correlation, the reference code has greater intra-service time compared to 77301, 201 minutes and 160 minutes, respectively. In addition, the RUC reviewed MPC CPT code 95951 *Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours* (work RVU= 5.99) and agreed that the two services have similar physician work. However, 77301 has 45 more minutes of physician time compared to the reference code and thus should be valued higher. **The RUC recommends a work RVU of 7.99 for CPT code 77301.**

Practice Expense: The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
77301		Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications (Dose plan is optimized using inverse or forward planning technique for modulated beam delivery [eg, binary, dynamic, MLC] to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetric verification of the intensity map with verification of treatment set-up and interpretation of verification methodology)	XXX	7.99 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77301 Tracking Number Original Specialty Recommended RVU: **7.99**
Presented Recommended RVU: **7.99**
Global Period: XXX RUC Recommended RVU: **7.99**

CPT Descriptor: Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male presenting with clinically localized, high grade adenocarcinoma of the prostate, PSA 16ng/ml. CT simulation is done and an IMRT plan is to be generated for radiation therapy to the prostate, seminal vesicles and pelvic nodes, and dose escalated radiation to the prostate and seminal vesicles.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work:
• Before the planning scans are transferred from the CT simulator into the treatment planning software, the radiation oncologist reviews the suitability of the patient positioning on the scanner and the planning CT scans obtained with the patient immobilized as ordered, to verify the visual integrity of the image data set to be used for dose calculations, clear recognition of any implanted fiducials to be used for later image guidance, appropriate administration of any contrast material used, and consistency of internal anatomy (rectal filling, bladder filling, bowel gas etc) with reference to expectations based on recent diagnostic imaging scans (15 min)

• The planning CT scans are uploaded into the treatment planning software, where the radiation oncologist again reviews the patient's internal anatomy with special attention to the tumor-bearing regions seen on relevant prior diagnostic imaging studies, including MRI and/or PET scan (5 min)

• The CT simulation images are fused with selected diagnostic image sets (MR images of the pelvis in this case) using image fusion techniques. The fusion is then manually adjusted by the physician to ensure accurate matching of fiducial markers and internal anatomy (15 minutes).

• The radiation oncologist outlines target volumes on the fused data set on each 3mm planning scan slice. The gross tumor volume (GTV), representing radiographically evident cancer-containing volume, is expanded into the clinical target volume (CTV), which includes the zone of potential microscopic disease extension. In the prostate case vignette, the GTV

is the prostate gland and the CTV includes the adjacent seminal vesicle, bilateral internal iliac nodes, sub-aortic pre-sacral nodes from S1-S3, and external iliac nodes out to the inguinal ligament. These contours are made slice by slice on the fused scans. Planning target volumes (PTV) are added to the initial and boost Clinical Target Volumes, which accounts for setup error and intrafraction motion. These are asymmetric margins, depending on expected organ motion and deformation, risk of toxicity to surrounding organs and type of image guidance used. (40 min)

• Important organs at risk (OARs) are also contoured on each 3 mm planning scan slice and labeled; for the prostate case vignette, these include pelvic small bowel loops, rectum and rectosigmoid, bilateral femoral heads, bladder, and penile bulb. The urethra is also identified to avoid an inadvertent dose "hotspot" in that structure. Identify and outline any fiducial markers in the prostate. (40 min)

• Prescribe the intended dose to elements of the PTV, to include the prostate, seminal vesicles, and pelvic lymph nodes. (3 min)

• Define partial dose/volume tolerances for each OARs and specify normal tissue and tumor dose constraints for the inverse planning algorithm. (8 min)

• Designate priorities (or rankings) of the target volumes and OAR's for the inverse planning algorithm. (2 min)

• Evaluate initial plan to determine whether intended goal dose to PTV and dose constraints to OARs have been achieved. (8 min)

• Work with the dosimetrist and physicist to modify the optimization parameters iteratively to achieve an acceptable dose to the target volumes while respecting the normal tissue tolerance doses. During this process, multiple plans are generated and compared with reference to adequacy of tumor coverage, location of dose "hot spots" and "cold spots", and risk of normal tissue injury based on the dose volume histograms for tumor and critical normal tissues until a properly optimized plan is selected. (20 min)

• The planned dose for that patient is delivered to a phantom (diode array or equivalent). A comparison plan is calculated based on the patient plan, and the physician compares the delivered dose to the comparison plan using quantitative metrics (gamma analysis, DTA, or other quantities) to confirm that there are no significant variations between the two measurements. (5 min)

Description of Post-Service Work:

• Review graphical and tabular summaries of dose volume histograms for target structures and OARs for compliance with plan specifications, review planar (axial, coronal, sagittal) illustrations of the approved dose distribution within the patient, and sign an e-copy of these elements of the plan documentation for storage in the treatment planning system backup files

• Verify that patient setup instructions have been entered into the appropriate place within the electronic medical record and that the beam angles, and gantry positions unique to the patient's plan have been entered into the section of the electronic medical record that will record and verify each treatment given

• Sign the IMRT prescription in the patient's electronic medical record

• Discuss with members of the treatment team (physicist, dosimetrist, therapist, nurse) patient-specific considerations regarding implementation of the IMRT plan

• Dictate IMRT procedure note

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Najeeb Mohideen, MD, Michael Kuettel, MD, PhD, Dwight Heron, MD and Gerald White		
Specialty(s):	Radiation Oncology		
CPT Code:	77301		
Sample Size:	880	**Resp N:** 90	**Response:** 10.2 %
Description of Sample:	We discussed our sample selection process with the Research Subcommittee prior to fielding the survey. We published a blurb in the Society weekly communication that asked for people to complete a health policy survey. We collected those names and sent them a survey. We also sent surveys to ALL of our members who have indicated in their membership file that this is a modality they practice. Finally, we sent additional surveys to another 250 randomly selected active, US members.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	35.00	**55.00**	108.00	250.00
Survey RVW:	3.55	8.00	**8.70**	9.10	12.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	30.00	90.00	**160.00**	174.00	240.00

Immediate Post Service-Time:	**35.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	77301	**Recommended Physician Work RVU: 7.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**160.00**		

Immediate Post Service-Time:	**35.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**

Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77435	XXX	11.87	**RUC Time**

CPT Descriptor Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95951	XXX	5.99	**RUC Time**	63,459

CPT Descriptor 1 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99475	XXX	11.25	**RUC Time**	64

CPT Descriptor 2 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

Other Reference CPT Code	Global	Work RVU	Time Source
77427	XXX	3.37	**RUC Time**

CPT Descriptor Radiation treatment management, 5 treatments

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 59 **% of respondents:** 65.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 77301**	**Key Reference CPT Code:** 77435	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	20.00	
Median Intra-Service Time	160.00	210.00	
Median Immediate Post-service Time	35.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**195.00**	**250.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.41	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.54	4.47
Urgency of medical decision making	3.98	4.03
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.59	4.53
Physical effort required	3.98	3.98
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.49	4.54
Outcome depends on the skill and judgment of physician	4.69	4.69
Estimated risk of malpractice suit with poor outcome	4.31	4.36

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.49	4.49
Post-Service intensity/complexity	4.07	4.08

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 77301 is an IMRT planning code billed once per course of treatment for an IMRT case which has PC and TC. The PC describes the physician work associated with IMRT planning . There is an IMRT delivery code, CPT 77418, that is coded separately to describe the delivery of radiation and the delivery codes do NOT include physician work.

ASTRO conducted a survey and collected 90 random surveys. ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. ASTRO recommends maintaining the current RVU of 7.99 for CPT code 77301. Our rationale for that recommendation is based on multiple factors and is described below.

Vignette

The Medicare data indicates that our original vignette describing a patient with high risk prostate cancer in *2001* is in fact the most reported diagnosis (ICD 185) for this CPT code. Therefore, we used the original vignette, with extraneous information removed (and approved by the research subcommittee) in this survey and 95 % of our survey respondents felt the vignette was typical.

Codes Reported on the Same Day

The data in the "Same Day Billings from CMS" file shows that no codes are billed frequently with 77301. A basic radiation dosimetry calculation is billed approximately 52% of the time with 77301. CPT Code 77300 has 15 minutes of physician work and 0.62 wRVUs. CPT code 77300 is a separate and distinct service from 77301. It describes the work related to performing a primary and a secondary confirmatory calculation to get to the monitor units that the therapist enters into the treatment machine (Linac) that will be delivered per field. Calculating the relationship between dose and Monitor Units requires specific inputs related to this calculation and machine output factors characteristic of the linear accelerator and this determines the number of Monitor Units the therapist enters to deliver the treatment as prescribed by the physician.

Time

Our current surveyed total time is 195 minutes (0, 160, 35), which is essentially the same as the current total time of 196 minutes (30, 131, 35). The total time is broken out slightly different in the current survey, than in the RUC database.

There has been much debate and confusion about XXX codes and whether they have pre/post work. There are many RO XXX codes that do not have pre and/or post time. We believe it is appropriate for this code to have post time. However, we believe all other activities would be appropriately considered intra time. We brought this issue to the research subcommittee prior to fielding the survey. We were granted permission to remove the "pre time" question/definition from the survey and provide a more robust definition of intra time for the survey respondents.

While the vignette is unchanged from 2000, at that time IMRT was predominantly used as a boost to the prostate after intial 3D external beam radiation therapy to the pelvis. Currently the technology permits us (and it is typical) to do the pelvic volumes and prostate boost as one IMRT plan with no separate 3 D plan. Hence this increases the number of target volumes and critical structures contoured and the number of different critical structures that has to be kept within specific dose constraints and is appropriately reflected in the surveyed intraservice time of 160 minutes.

IWPUT

The current IWPUT for CPT code 77301 is 0.0499. With our recommendations our IWPUT will be 0.045. The difference in these two intensities relates to shift in time from pre to intra. The survey responders picked CPT 77435 as the reference service codes and also scored CPT 77301 as less intense than the reference service code. We believe our current recommendations supports this slight change in IWPUT, maintains the relationship between the surveyed code and the reference service code and stays in line with other radiation oncology IWPUTs.

Comparison to the Key Reference Services:

Our recommendations maintain relativity within the radiation oncology family. The key reference service code, 77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions is also an XXX code, has a total time of 250 minutes, an IWPUT of 0.0523 and a wRVU of 11.87. The surveyed code has less time and fewer RVUs than the reference code but nearly equal intensity. Both codes are fundamentally similar with a high degree of complex planning, image evaluation and clinical correlation, in collaboration with the medical physicist and dosimetrist. However 77435 was ranked slightly higher in urgency of medical decision making and psychological stress in view of the real time delivery of ultra high doses of radiation during radiosurgery and thus merits the higher IWPUT of 0.0523 in comparison to 77301 which has an IWPUT of 0.045. Both 77301 and 77435 may be reported only once during the entire course of therapy. We believe that this was an appropriate selection by our survey respondents and fits nicely with our survey data. Our recommendations also fit nicely with CPT code 77427 Radiation treatment management, 5 treatments which has a total time of 101 minutes, a wRVU of 3.37 and an IWPUT of 0.0345.

Relativity will also be maintained compared to other codes on the MPC list. For example, CPT code 95951 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and

video recording and interpretation (eg, for presurgical localization), each 24 hours has a total time of 150 minutes, a wRVU of 5.99 and an IWPUT of 0.066. This code describes the physician work of analyzing and interpreting seizure activity over this period to localize the seizure source. The surveyed code has 45 more minutes (195 vs 150) and a lower IWPUT (0.045 vs 0.066). Another MPC code, 99475 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age has a total time of 165 minutes, a wRVU of 11.25 and an IWPUT of 0.0943. Our recommendations maintain relativity compared to this code. The surveyed code has 30 more intra minutes but a significantly lower IWPUT and RVU.

Volume Growth:
Volume Growth for IMRT planning has plateaued over the last couple years.

IMRT in the Office Setting

		2012		2011		2010	
77301	IMRT Planning	0%	90,639	8%	90,214	6%	83,884

Building Block
The consensus panel also used a building block to validate our recommendations. Again, IMRT planning code reflects a "complete course" of therapy including, at a minimum, acquisition and 3 D Rendering of CT volumes, 3D target volume contouring and special dosimetry measurements throughout the volume. The following codes were used as a "cross check" of our recommendation. The 3D target contouring work approximates the work of CPT 77295, 3D simulation, (4.56), the patient specific special measurements at multiple points throughout the target volumes approximates + three 77331,Special radiation dosimetry measurement, (3 x 0.87) + the CT acquisition and 3D rendering is similar to the work of one 77014,CT scan for radiation therapy guide, (0.85) and one 76376, 3D render w/o postprocess, (0.20) = 8.22, which is right in line with our median of 8.00. These codes would not be billed along with this new code.

Recommendations:
We are recommending the current RVUw of 7.99, pre-service: zero minutes, median intra time of 160 minutes and post service times of 35 minutes, for a total time of 195 minutes. We believe our 90 person survey supports our recommendations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The data in the “Same Day Billings from CMS” file shows that no codes are billed frequently with 77301. A basic radiation dosimetry calculation is billed approximately 52% of the time with 77301. CPT Code 77300 has 15 minutes of physician work and 0.62 wRVUs. CPT code 77300 is a separate and distinct service from 77301. It describes the work related to performing a primary and a secondary confirmatory calulation to get to the monitor units that the therapist enters into the treatment machine (Linac) that will be delivered per field. Calculating the relationship between dose and Monitor Units requires specific inputs related to this calculation and machine output factors characteristic of the linear accelerator and this determines the number of Monitor Units the therapist enters to deliver the treatment as prescribed by the physician.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77301

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 130000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that approximatley 130,000 IMRT plans are done nationally in a one-year period. The median age for prostate cancer is 68, so most prostate IMRT cases would be in the Medicare population. We estimated an additional 35,000 cases to account for the prostate cancers in the non Medicare population and the other types of cancers treated with IMRT (a little less than half of the Medicare utilization number).

Specialty Radiation Oncology Frequency 123500 Percentage 95.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 90,639 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Radiation Oncology Frequency 86109 Percentage 95.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77301

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS	AT
1	**ISSUE:**	**Radiotherapy Dose Plan IMRT**																								
2	**TAB:**	**46**																								
3						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE					
4	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX	TYP
5	REF	77435	Stereotactic body radiation the		0.052			####			250	20					210			20						
6	CURRENT	77301	Intensity modulated radiothera		0.050			7.99			196	30					131			35						
7	SVY	77301	Intensity modulated radi	90	0.049	3.55	8.00	8.70	9.10	12.00	195				30	90	160	174	240	35	1	35	55	108	250	89%
8	REC				0.045			7.99			195						160			35						

CPT Code: 77301
Specialty Society('s) ASTRO

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications*

Global Period: XXX **Meeting Date:** 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ASTRO developed these PE recommendations by Consensus Panel. The Panel had several radiation oncologists and medical physicists. The group reviewed the existing direct practice expense inputs for this procedure as well as several other radiation oncology codes.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

We did not include a reference code with these recommendations, as the surveyed code is an existing code. We did include the existing direct PE inputs as for reference on the spreadsheet.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The nursing staff will Complete pre-service diagnostic & referral forms, discuss the forms and necessary referrals with the patient and make calls to the practices to which the patient has been referred as necessary.

Service Clinical Labor Activities:

The nursing staff will greet patient, provide gowning and ensure appropriate medical records are available for the procedure. They will then obtain vital signs and Provide pre-service education/obtain consent.

The Radiation Therapist will prepare room, equipment, supplies for the CT based procedure. Once the nursing staff has completed their work with the patient, the Radiation Therapist will Prepare and position patient on the CT table.

The Radiation Therapist Aligns the patient with respect to the scan center of the CT scan and the plane of the CT table using three or four externally mounted lasers that are positioned in the same way as the alignment lasers in the linac treatment room. They then mark the patient with radiopaque markers, and then take multiple AP and Lat scout scans and adjust patient position after each scout such that at the end of the process the patient is aligned without rotation in the x,y and z axis and the external markers are appropriately centered for the area to be imaged and that the patient is comfortable in this position, or else this is adjusted.

The Radiation Therapist then selects the appropriate CT technique based on the anticipated needs of the IMRT process, acquires and processes the CT data set scan. They then discuss the acquired images with the physician, evaluating appropriate bladder, rectal filling. After approval, the patient is marked with tattoos at the external markers or at a preselected isocenter. The data is then transferred to the treatment planning computer.

The medical physicist evaluates the planning CT for artifacts and Hounsfield Unit anomalies. He or she will then evaluate fusion image data sets for appropriate voxel characteristics and if acceptable fuse image data sets.

The contouring phase:

A combination of the medical physicist and medical dosimetrist contour the external contour(s) of the patient, table and devices, review all M.D. created contours with physician, interpolate contours & create expansions for CTV and PTV based on M.D. contouring and Rx, create density overrides, review the entire final 3-D contour set with physician.

After the initial contouring is completed, the medical physicist will review all contours for high spatial frequency characteristics that may interfere with the sampling voxels of the optimization algorithm kernel. Perform contour vertex expansion/reduction as necessary.

The Medical Physicist will perform Boolean operations on contours to resolve optimization constraint and objective conflicts and create synthetic structure contours for use in optimization and evaluation.

Next is the planning phase:

The dosimetrist will enumerate critical normal tissues adjacent to tumor volume, enter partial dose/volume objectives and constraints for normal tissues and PTV's, Dosimetrist, physicist and physician create initial gantry and table angles for field families, Evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints, Modify tumor and normal tissue dose constraints if necessary to re-run plan, iterate plan until dose constraints are acceptable, typically creating a series of possible optimization endpoints for later comparison and selection.

After initial optimizations are completed, the medical physicist will evaluate dose plan distribution and objective function values for excessive influence of non-unit density HU values, modify and override densities as necessary. The physicist will then re-run plans with optimized parameters. He or she will then evaluate and rank plans for physics and radiobiological-based optimization using a dose response index for the probability of uncomplicated tumor control.

After the physician has completed the review of the above described plan and options and selected the final isodose plan to be delivered, the dosimetrist will review plan, transfer to R&V system, create synthetic orthogonal isocenter digitally reconstructed radiographs, calculate and transfer phantom planar dose sets and create staff worklists.

Delivery verification process:

In the final stage, the medical physicist verifies the plan by delivering the dose distribution to a phantom with appropriate dose measuring devices. The physicist will acquire, process and review phantom/film/EPID or diode Dosimetry referenced to ion chamber single point dosimetry to confirm correct dose delivery compared with graphical plan. He or she will prepare a gamma analysis (distance to agreement and relative dose correspondence) for Physician review. Investigate any anomalous results and modify isodose plan, dose rate, etc. as necessary.

Post-Service Clinical Labor Activities:

At the conclusion of the image acquisition portion of the procedure the Radiation Therapist will clean and replace equipment used for the patient. The nursing staff will coordinate necessary prescriptions with the physician and call the pharmacy, instruct the patient and perform follow up phone calls to the patient.

	A	B	C	D	E	F	G
1							
2				**77301**		**77301**	
3	**Meeting Date: April 2012** **Tab: 46** **Specialty: Radiation Oncology**	**CMS Code**	**Staff Type**	*IMRT plan, including dose-volume histograms for target and critical structure partial tolerance specifications*			
4				***Existing Inputs Approved April 2001***		***Recommendations***	
5	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
6	**GLOBAL PERIOD**						
7	**TOTAL CLINICAL LABOR TIME**			**401**	**0**	**391**	**0**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**12**	**0**	**12**	**0**
9	*RN/LPN/MTA*	*L037D*		*2*		*2*	
10	*Medical Physicist*	*L152A*		*10*		*10*	
11	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**379**	**0**	**369**	**0**
12	*RN/LPN/MTA*	*L037D*		*16*		*6*	
13	*Radiation Therapist*	*L050C*		*48*		*48*	
14	*Medical Dosimetrist/Medical Physicist*	*L107A*		*45*		*45*	
15	*Medical Physicist*	*L152A*		*270*		*270*	
16	**TOTAL POST-SERV CLINICAL LABOR TIME**			**10**	**0**	**10**	**0**
17	*RN/LPN/MTA*	*L037D*		*10*		*10*	
18	**PRE-SERVICE**						
19	**Start: Following visit when decision for surgery or procedure made**						
20	Complete pre-service diagnostic & referral forms		RN/LPN/MTA	2		**2**	
21	Coordinate pre-surgery services						
22	Schedule space and equipment in facility						
23	Provide pre-service education/obtain consent						
24	Follow-up phone calls & prescriptions						
25	Other Clinical Activity - *specify: PrePlanning*	L152A	MedPhys	10		**10**	
26	**End: When patient enters office/facility for surgery/procedure**						
27	**SERVICE PERIOD**						
28	**Start: When patient enters office/facility for surgery/procedure:**						
29	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		**3**	
30	Obtain vital signs	L037D	RN/LPN/MTA	3		**0**	
31	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	10		**3**	
32	Prepare room, equipment, supplies	L050C	Rad Therapist	10		**2**	
33	Setup scope (non facility setting only)						
34	Prepare and position patient/ monitor patient/ set up IV	L050C	Rad Therapist	15		**2**	
35	Sedate/apply anesthesia						
36	**Intra-service**			335			
37	Align and Mark Patient: Acquire and process CT scan/review and transfer data set	L050C	Rad Therapist			**41**	
38	Image correlation and Manipulation: Correlate planning CT with other imaging studies, Fusion,	L152A	MedPhys				
39	Contouring: Outline external contour(s), table and devices, review all M.D. created contours with physician, interpolate contours & create expansions based on M.D. contouring and Rx.	L107A	MP/Dos				
40	Planning: Enumerate critical normal tissues adjacent to tumor volume, enter partial dose/volume objectives and constraints for normal tissues and PTV's, Dosimetrist, physicist and physician create initial gantry and table angles for field families, evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints, modify tumor and normal tissue dose constraints if necessary to re-run plan, iterate plan until dose constraints are acceptable, review plan, transfer to R&V system, Create synthetic orthogonal isocenter digitally reconstructed radiographs, calculate and transfer phantom planar dose sets, create staff worklists.	L107A	MP/Dos				

	A	B	C	D	E	F	G
1							
2				**77301**		**77301**	
3	**Meeting Date: April 2012** **Tab: 46** **Specialty: Radiation Oncology**	**CMS Code**	**Staff Type**	*IMRT plan, including dose-volume histograms for target and critical structure partial tolerance specifications*			
4				***Existing Inputs Approved April 2001***		***Recommendations***	
5	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
6	**GLOBAL PERIOD**						
41	Contouring and Planning: Perform Boolean combinations on structure data sets, create density overrides, evaluate and correct for MR and CT distortions,. After the initial contouring is completed, the medical physicist will review all contours for high spatial frequency characteristics that may interfere with the sampling voxels of the optimization algorithm kernel. Perform contour vertex expansion/reduction as necessary. Review the entire final 3-D contour set with physician. After initial optimizations are completed, the medical physicist will evaluate dose plan distribution and objective function values for excessive influence of non-unit density HU values, modify and override densities as necessary. The physicist will then re-run plans with optimized parameters. He or she will then evaluate and rank plans for physics and radiobiological-based optimization using a dose response index for the probability of uncomplicated tumor control.	L152A	MedPhys				
42	Plan Verification: Acquire, Review phantom/film/EPID or diode dosimetry referenced to ion chamber single point dosimetry to confirm correct dose delivery compared with graphical plan.	L152A	MedPhys				
43	**Post-Service**						
44	Monitor pt. following service/check tubes, monitors, drains						
45	Clean room/equipment by physician staff	L050C	Rad Therapist	3		**3**	
46	Clean Scope						
47	Clean Surgical Instrument Package						
48	Complete diagnostic forms, lab & X-ray requisitions						
49	Review/read X-ray, lab, and pathology reports						
50	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
51	Other Clinical Activity - *specify:*						
55	**End: Patient leaves office**						
56	**POST-SERVICE Period**						
57	**Start: Patient leaves office/facility**						
58	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	10		**10**	
66	Other Clinical Activity - *specify:*						
67	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1							
2				**77301**		**77301**	
3	**Meeting Date: April 2012** **Tab: 46** **Specialty: Radiation Oncology**	**CMS Code**	**Staff Type**	*IMRT plan, including dose-volume histograms for target and critical structure partial tolerance specifications*			
4				***Existing Inputs Approved April 2001***		***Recommendations***	
5	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
6	**GLOBAL PERIOD**						
68	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
69	pack, minimum multi-specialty visit	SA048	pack			1	
70	markers, radiographic, multi-modality	SD096		4		4	
71	tray, catheter insertion (w-o catheter)	SA063		1		1	
72	catheter, Foley	SD024				1	
73	gloves, non-sterile	SB022		4		2	
74	film, x-ray 8in x 10in	SK038		20		*20*	
75	film, x-ray 14in x 17in	SK034		6		*6*	
76	film, dry, radiographic, 8in x 10in	SK025		6		*6*	
77	x-ray developer solution	SK089		20		*20*	
78	acetone	SL001		6		*6*	
79	computer media, optical disk	SK015		0.33		*0.33*	
80	computer media, floppy disk	SK014		1		*1*	
81	paper, photo printing (8.5 x 11)	SK058		20		*20*	
82	transparency	SK083		6			
83	styrofoam block, high density	SD120		1			
84	bite block	SD006		1			
85							
86	**EQUIPMENT**	**CODE**					
87	IMRT CT-based simulator	ER005		90		**47**	
88	Treatment planning system, IMRT	ED033		400		**330**	
89	accelerator, 6-18 MV	ER010				**0**	
90	IMRT physics tools	ER006		15		**15**	
91	phantom, solid water calibration	ER050		20		**47**	
92	chamber, Farmer-type	ER014				**47**	
93	electrometer, PC-based, dual channel	ER028				**47**	
94	computer system, record and verify	ED011				**0**	
95	printer, dye sublimation	ED031		15		**15**	
96	*film processor, dry, laser*	*ED024*		*15*		*15*	
97	*film dosimetry equipment-software*	*ER030*		*60*		*60*	
98	*film processor, wet*	*ED025*		*15*		*15*	
99	optical drive (MO), external	ED029		10			
100	computer software, MR/PET/CT	ED010		15			
101	computer, server	ED022		20			
102	TLD Reader	EP002		90			
103	TLD annealing furnace	EP003		60			
104	IMRT accelerator	ER089				**47**	

	A	B	C	D	E	F	G
1							
2				**77301**		**77301**	
3	**Meeting Date: April 2012** **Tab: 46** **Specialty: Radiation Oncology**	**CMS Code**	**Staff Type**	*IMRT plan, including dose-volume histograms for target and critical structure partial tolerance specifications*			
4				***Existing Inputs Approved April 2001***		***Recommendations***	
5	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
6	**GLOBAL PERIOD**						
7	**TOTAL CLINICAL LABOR TIME**			**401**	**0**	**392**	**0**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**12**	**0**	**2**	**0**
9	*RN/LPN/MTA*	*L037D*		*2*		*2*	
10	*Medical Physicist*	*L152A*		*10*			
11	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**379**	**0**	**387**	**0**
12	*RN/LPN/MTA*	*L037D*		*16*		*9*	
13	*Radiation Therapist*	*L050C*		*48*		*48*	
14	*Medical Dosimetrist/Medical Physicist*	*L107A*		*45*		*120*	
15	*Medical Physicist*	*L152A*		*270*		*210*	
16	**TOTAL POST-SERV CLINICAL LABOR TIME**			**10**	**0**	**3**	**0**
17	*RN/LPN/MTA*	*L037D*		*10*		*3*	
18	**PRE-SERVICE**						
19	**Start: Following visit when decision for surgery or procedure made**						
20	Complete pre-service diagnostic & referral forms		RN/LPN/MTA	2		**2**	
21	Coordinate pre-surgery services						
22	Schedule space and equipment in facility						
23	Provide pre-service education/obtain consent						
24	Follow-up phone calls & prescriptions						
25	Other Clinical Activity - *specify: PrePlanning*	L152A	MedPhys	10			
26	**End: When patient enters office/facility for surgery/procedure**						
27	**SERVICE PERIOD**						
28	**Start: When patient enters office/facility for surgery/procedure:**						
29	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		**3**	
30	Obtain vital signs	L037D	RN/LPN/MTA	3		**3**	
31	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	10		**3**	
32	Prepare room, equipment, supplies	L050C	Rad Therapist	10		**2**	
33	Setup scope (non facility setting only)						
34	Prepare and position patient/ monitor patient/ set up IV	L050C	Rad Therapist	15		**2**	
35	Sedate/apply anesthesia						
36	**Intra-service**			335			
37	Align and Mark Patient: Acquire and process CT scan/review and transfer data set	L050C	Rad Therapist			**41**	
38	Image correlation and Manipulation: Correlate planning CT with other imaging studies, Fusion,	L152A	MedPhys			**40**	
39	Contouring: Outline external contour(s), table and devices, review all M.D. created contours with physician, interpolate contours & create expansions based on M.D. contouring and Rx.	L107A	MP/Dos			**40**	
40	Planning: Enumerate critical normal tissues adjacent to tumor volume, enter partial dose/volume objectives and constraints for normal tissues and PTV's, Dosimetrist, physicist and physician create initial gantry and table angles for field families, evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints, modify tumor and normal tissue dose constraints if necessary to re-run plan, iterate plan until dose constraints are acceptable, review plan, transfer to R&V system, Create synthetic orthogonal isocenter digitally reconstructed radiographs, calculate and transfer phantom planar dose sets, create staff worklists.	L107A	MP/Dos			**80**	

	A	B	C	D	E	F	G
1							
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3	**Meeting Date: April 2012** **Tab: 46** **Specialty: Radiation Oncology**	**CMS Code**	**Staff Type**	*IMRT plan, including dose-volume histograms for target and critical structure partial tolerance specifications*			
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5	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
6	**GLOBAL PERIOD**						
41	Contouring and Planning: Perform Boolean combinations on structure data sets, create density overrides, evaluate and correct for MR and CT distortions,. After the initial contouring is completed, the medical physicist will review all contours for high spatial frequency characteristics that may interfere with the sampling voxels of the optimization algorithm kernel. Perform contour vertex expansion/reduction as necessary. Review the entire final 3-D contour set with physician. After initial optimizations are completed, the medical physicist will evaluate dose plan distribution and objective function values for excessive influence of non-unit density HU values, modify and override densities as necessary. The physicist will then re-run plans with optimized parameters. He or she will then evaluate and rank plans for physics and radiobiological-based optimization using a dose response index for the probability of uncomplicated tumor control.	L152A	MedPhys			**80**	
42	Plan Verification: Acquire, Review phantom/film/EPID or diode dosimetry referenced to ion chamber single point dosimetry to confirm correct dose delivery compared with graphical plan.	L152A	MedPhys			**90**	
43	**Post-Service**						
44	Monitor pt. following service/check tubes, monitors, drains						
45	Clean room/equipment by physician staff	L050C	Rad Tech	3		**3**	
46	Clean Scope						
47	Clean Surgical Instrument Package						
48	Complete diagnostic forms, lab & X-ray requisitions						
49	Review/read X-ray, lab, and pathology reports						
50	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
51	Other Clinical Activity - *specify:*						
55	**End: Patient leaves office**						
56	**POST-SERVICE Period**						
57	**Start: Patient leaves office/facility**						
58	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	10		**3**	
66	Other Clinical Activity - *specify:*						
67	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1							
2				**77301**		**77301**	
3	**Meeting Date: April 2012** **Tab: 46** **Specialty: Radiation Oncology**	**CMS Code**	**Staff Type**	*IMRT plan, including dose-volume histograms for target and critical structure partial tolerance specifications*			
4				***Existing Inputs Approved April 2001***		***Recommendations***	
5	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
6	**GLOBAL PERIOD**						
68	**MEDICAL SUPPLIES**	**CODE**	**UNIT**				
69	pack, minimum multi-specialty visit	SA048	pack			1	
70	markers, radiographic, multi-modality	SD096		4		4	
71	tray, catheter insertion (w-o catheter)	SA063		1		1	
72	catheter, Foley	SD024				1	
73	gloves, non-sterile	SB022		4		2	
74	film, x-ray 8in x 10in	SK038		20		*20*	
75	film, x-ray 14in x 17in	SK034		6		*6*	
76	film, dry, radiographic, 8in x 10in	SK025		6		*6*	
77	x-ray developer solution	SK089		20		*20*	
78	acetone	SL001		6		*6*	
79	computer media, optical disk	SK015		0.33		*0.33*	
80	computer media, floppy disk	SK014		1		*1*	
81	paper, photo printing (8.5 x 11)	SK058		20		*20*	
82	transparency	SK083		6			
83	styrofoam block, high density	SD120		1			
84	bite block	SD006		1			
85							
86	**EQUIPMENT**	**CODE**					
87	IMRT CT-based simulator	ER005		90		**58**	
88	Treatment planning system, IMRT	ED033		400		**376**	
89	accelerator, 6-18 MV	ER010				**45**	
90	IMRT physics tools	ER006		15		**60**	
91	phantom, solid water calibration	ER050		20		**45**	
92	chamber, Farmer-type	ER014				**45**	
93	electrometer, PC-based, dual channel	ER028				**45**	
94	computer system, record and verify	ED011				**20**	
95	printer, dye sublimation	ED031		15		**15**	
96	*film processor, dry, laser*	*ED024*		*15*		*15*	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes screen

April 2012

Visual Field Exams

In July 2011, CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU=0.50), was identified through the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC recommended that the specialty societies survey this service. CPT codes 92081 and 92082, which are part of this family of services were recently reviewed in April 2010 and were not resurveyed.

In April 2012, the RUC reviewed the survey results from 116 ophthalmologists and optometrists for CPT code 92083 and determined that the work RVU of 0.50, the survey's 25th percentile accounts for the physician work required to perform this service. The RUC discussed that survey respondents included post-service time which should not be included based on the RUC guidelines developed for 92081 and 92082 in 2005. The RUC also agreed that the respondents underestimated the physician work involved in the intra-service time because they did not recognize that the interpretation and creation of the report is included in the intra-service time, as stated in the descriptor. Nothing has changed about the service since it was last reviewed in 2005 so for consistency and recognition of the interpretation and creation of the report being part of intra-service work, the RUC agreed that times should be modified from the survey to 3 minutes pre-service, 10 minutes intra-service and 0 minutes post-service. The RUC compared 92083 to key reference CPT code 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU=0.40) and determined that 92083 requires slightly more physician time and is more intense to perform, justifying the higher RVU value. **The RUC recommends a work RVU of 0.50 for CPT code 92083.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
92081		Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	XXX	0.30 (No Change) RUC Reviewed in April 2010
92082		intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	XXX	0.40 (No Change) RUC Reviewed in April 2010
92083		extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2) (Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately)	XXX	0.50 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92083 Tracking Number Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 69 year old with a 3-year history of open angle glaucoma

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's chart is reviewed for pertinent data and prior visual field results. The refractive error is determined from the past record or from neutralization of the current spectacles. The refractive correction for perimetry is calculated. The appropriate level of visual field to be performed is determined.

Description of Intra-Service Work: The extensive test results for each eye are reviewed by the physician to assess the reliability and consistency of the responses. Multiple data points are compared with previous visual fields to determine the extent, distribution, pattern and change of the visual field loss. Global indices are reviewed and compared to prior studies. An interpretation and report is generated for the patient record. Interpretation of the visual field results for each separately including reliability, normality, abnormality, change or artifact is recorded by the physician in the chart.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Stephen A Kamenetzky, M.D. and Michael Chaglasian, O.D.		
Specialty(s):	American Academy of Ophthalmology and American Optemetric Association		
CPT Code:	92083		
Sample Size:	1000	**Resp N:** 116	**Response:** 11.6 %
Description of Sample:	Random sample of names were derived from AAO and AOA membership data base as well as from American Glaucoma Society and North American Neuro-Ophthalmology Society		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	120.00	**400.00**	750.00	4000.00
Survey RVW:	0.35	0.50	**0.55**	0.70	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	4.00	**8.00**	15.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	92083	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92082	XXX	0.40	**RUC Time**

CPT Descriptor Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,352,877

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
92134	XXX	0.50	**RUC Time**

CPT Descriptor Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 56 **% of respondents:** 48.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 92083**	**Key Reference CPT Code:** 92082	**Source of Time** **RUC Time**
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	10.00	8.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**13.00**	**11.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.70
Urgency of medical decision making	3.54	3.23
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.55	3.29
Physical effort required	2.68	2.57
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.48	3.16
Outcome depends on the skill and judgment of physician	4.00	3.68
Estimated risk of malpractice suit with poor outcome	3.84	3.59

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.14	2.80
Intra-Service intensity/complexity	3.59	3.21
Post-Service intensity/complexity	3.89	3.41

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code (CPT *92083 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* was selected for review by CMS because it has a high volume and has not been reviewed since August 2005. Currently, it has an intra-service work of 0.50 WRVU with times of 3/10/0. The other two codes in the family were reviewed in April 2010 and were not resurveyed. It has been the RUC's position that, for all of the codes in this family, the intra-service work includes the interpretation and report. The test is used to follow the progression of patients with glaucoma and to evaluate neurologic, optic nerve and retinal pathology. There has been no significant change in technology related to this service since it was previously surveyed in 2005.

There were 116 respondents (11.6% response rate) to the joint AAO-AOA survey and over 90% felt that the vignette was typical. The 25th percentile WRVU was 0.50 and the median WRVU 0.55. The median times were 5/8/5 minutes. The predominant reference code chosen was CPT 92082, a less-sophisticated visual field test. Both the surveyed code and the reference code have "unilateral or bilateral" in the descriptor. The code is typically associated with an office visit on the day of service**.**

An expert consensus panel composed ophthalmologists and optometrists familiar with the RUC process and visual field testing reviewed the survey results. The panel felt that the pre-service time of 5 minutes was too long and that the values for intra-service and post-service time should conform to the RUC guideline developed for 92081 and 92082. That guideline established that there was no post-service time and all of the physician work should be captured in the intra-service time. After consideration of these factors, the consensus panel adjusted the survey times slightly and is recommending **4/10/0 minutes, which is one minute more pre-service time than the primary reference service (3/8/0),** but one minute less than the survey value. The consensus group felt that the intra-service time was unchanged from the 10 minutes in the data base.

The panel also reviewed the evaluation of the work of 92083 when compared to the reference code. Survey respondents indicated that the mental effort and judgment, technical skill and psychological stress were all greater than the reference code. The panel agreed. The panel felt that the 25th percentile accurately captured the work of the test and therefore the **societies are recommending a WRVU of 0.50 which is the 25th percentile in the survey. This is the same as the current value of the code.**

There are other recently RUC-valued XXX codes with similar times and work values. CPT 92134 (*Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina)* has a WRVU of 0.50 and times of 7/10/0. The panel felt that the intra-service work of 92083 was slightly more intense although the pre-time was shorter. CPT 92133 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve* also has a WRVU of 0.50 and times of 3/10/0. CPT 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (RUC 2009, WRVU=0.56, 4/10/4) and CPT *93279 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system* (RUC 2008, wrvu=.65, 5/10/5) have similar times and slightly higher WRVUs.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Billed with an office visit

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
92002	5	15	5	25	.88	XXX
92004	5	25	10	40	1.82	XXX
92012	5	15	5	25	.92	XXX
92014	5	24	8	37	1.42	XXX
99213	3	15	5	23	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty Optometry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,600,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty Ophthalmology Frequency 2000000 Percentage 76.92 %

Specialty Optometry Frequency 600000 Percentage 23.07 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92083

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: 92083 Visual Field Exam

TAB: 46

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF	92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	37	0.042			0.40			11	3					8			0																			
CURRENT	92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	68	0.043			0.50			13	3					10																						
SVY	92083		116	0.041			0.50			14	4					10																						
REC				0.041			0.50			14	4					10																						

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Global Period: **XXX** Meeting Date: **April 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The societies convened a panel of experts to review and develop inputs by phone and email.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: **This is an existing code and so the current inputs of 92083 should be compared as well as two lower level codes (92081/82).**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Not applicable.

Service Clinical Labor Activities:

The ophthalmic tech assures that the appropriate referral forms are complete and that the medical record is available for the physician. The tech also ensures that all supplies and equipment are available for the visual field test. The patient's name and birth date are entered into the machine and the type of visual field is selected from the menu. The staff seats the patient comfortably at the instrument. Detailed instructions are provided about what to expect and when and how to respond to the stimuli. The necessary spectacle correction is entered from information determined by the physician. An eye patch is placed over the opposite eye. This lens is placed as close as possible to the eye without the eyelashes touching it. The clicker response device is placed in the patient's hand and demonstrated to the patient. The patient is reminded to maintain forward fixation. Once the procedure is completed and the patient has been escorted back to the lane, the clinical staff confirms the patient information and then enters all of the isopter data that was collected into to the record.

Post-Service Clinical Labor Activities:

Not applicable.

	A	B	C	D	E	F	G	H	I
1									
2				**92081**		**92082**		**92083**	
3	**Meeting Date:** **Specialty:** **Tab: 46**			**Visual field examination, unilateral or bilateral, w/ interpretation & report; limited**		**Visual field examination, unilateral or bilateral, w/ interpretation & report; intermediate**		**Visual field examination, unilateral or bilateral, w/ interpretation & report; extended**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	XXX	XXX	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			**17.0**	**0.0**	**27.0**	**0.0**	**37.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**17.0**	**0.0**	**27.0**	**0.0**	**37.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity (please specify)								
18	**End:When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure**								
21	**Pre-service services**								
22	Review charts	L038A	COMT/COT/RN /CST	**0**		0		0	
23	Greet patient and provide gowning	L038A	COMT/COT/RN /CST	**0**		0		0	
24	Obtain vital signs	L038A	COMT/COT/RN /CST	**0**		0		0	
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L038A	COMT/COT/RN /CST	**0**		0		0	
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L038A	COMT/COT/RN /CST	**2**		2		2	
29	Sedate/apply anesthesia								
30	**Intra-service**								
31	Assist physician in performing procedure	L038A	COMT/COT/RN /CST	**10**		20		30	
32	**Post-Service**								
33	Monitor pt. following service/check tubes, monitors, drains								
34	Clean room/equipment by physician staff								
35	Clean Scope								
36	Clean Surgical Instrument Package								
37	Complete diagnostic forms, lab & X-ray requisitions								
38	Review/read X-ray, lab, and pathology reports								
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
40	Discharge day management 99238 --12 minutes 99239 --15 minutes								
41	Draw isopters/enter demographics	L038A	COMT/COT/RN /CST	**5**		5		5	
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care								
47	*List Number and Level of Office Visits*								
48	99211 16 minutes		16						
49	99212 27 minutes		27						
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Other								
54									
55	*Total Office Visit Time*			**0**	**0**	**0**	**0**	**0**	**0**
56	Other Activity (please specify)								
57	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
2				92081		92082		92083	
3	**Meeting Date:** **Specialty:** **Tab: 46**			**Visual field examination, unilateral or bilateral, w/ interpretation & report; limited**		**Visual field examination, unilateral or bilateral, w/ interpretation & report; intermediate**		**Visual field examination, unilateral or bilateral, w/ interpretation & report; extended**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
58	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**						
59	Ophthalmology visit pack, non-dilated	SA050	pack	**1**		1		1	
60	occluder	11515		**1**		1		1	
61									
62									
63									
64									
65									
66	**Equipment**	**CMS Code**	**Utilization Percentage**						
67	Humphrey visual field analyzer	EQ029		**1**		1		1	
68	Screening Lane	EL006		**12**		22		32	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes screen

April 2012

Cardiovascular Stress Tests

CMS identified code 93015 for cardiovascular stress test for review in the 2012 Medicare Proposed Rule because it had not been reviewed since before 2006 and had CY 2010 allowed charges of greater than $10 million at the specialty level. Related codes 93016 and 93018 were also surveyed and RUC reviewed in April 2012, as part of the Agency's request to review the entire family of services.

93015 ***Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report***
The RUC reviewed the survey data from 76 cardiologists and agreed with the specialty societies that there is no compelling evidence that the physician work has changed since the last valuation and recommends to maintain the current value of 0.75, below the survey's 25th percentile. The RUC reviewed the median survey physician times and noted that the respondents overestimated the pre and post time as it is not an accurate reflection of the physician time involved in the service. The RUC agreed that the current pre and post times are more appropriate for this service and recommends the following physician time components: pre-service time= 2 minutes, intra-service time= 20 minutes, post-service time= 4 minutes.

To justify the current work RVU of 0.75, the RUC reviewed CPT codes 76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (work RVU= 0.74) and CPT code 95971 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming* (work RVU= 0.78) and agreed that both had comparable physician work and identical intra-service times compared to the surveyed code. Therefore, the recommended value is appropriately aligned relative to similar services. **The RUC recommends a work RVU of 0.75 for CPT code 93015.**

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93016 ***Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, without interpretation and report***
The RUC reviewed the survey data from 53 cardiologists and agreed with the specialty societies that there is no compelling evidence that the physician work has changed since the last valuation and recommends to maintain the current value of 0.45, below the survey's 25th percentile. The RUC noted that while the current total time of 58 minutes, is overstated, the proposed median survey times were also too high. The RUC agreed that CPT codes 93016, physician supervision only, and 93018, physician interpretation and report only, should have times that are similar to that of CPT code 93015. Therefore, the RUC recommends the following physician time components for 93016: pre-service time= 2 minutes, intra-service time= 15 minutes, post-service time= 2 minutes.

To justify the current work RVU of 0.45, the RUC reviewed CPT code 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (work RVU= 0.38) and agreed that while the two services have identical intra-service time of 15 minutes, the surveyed code has pre and post time and thus should be valued slightly higher. In addition, the RUC reviewed CPT code 94620 *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)* (work RVU= 0.64) and noted that while both services have the same intra-service times, the reference code should be valued higher than 93016 because of greater total time, 40 minutes compared to 19 minutes. **The RUC recommends a work RVU of 0.45 for CPT code 93016.**

93018 ***Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only***
The RUC reviewed the survey data from 61 cardiologists and agreed with the specialty societies that there is no compelling evidence that the physician work has changed since the last valuation and recommends to maintain the current value of 0.30, below the survey's 25th percentile. However, the RUC disagreed with the proposed median survey time values for this service as it is an increase over the current times for this service. The RUC agreed that CPT codes 93016, physician supervision only, and 93018, physician interpretation and report only, should have times that are similar to that of CPT code 93015. Therefore, the RUC recommends the following physician time components for 93018: pre-service time= 2 minute, intra-service time= 5 minutes, post-service time= 4 minutes.

To justify the current work RVU of 0.30, the RUC reviewed CPT code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32) and agreed that the two services have analogous physician work and times and should be valued similarly. In addition, the RUC compared 93018 to the work RVUs of 93015 and 93016 and agreed that a work RVU of 0.30 was appropriate because when it is added to 93016 the work RVU is the same, 0.75, as 93015. **The RUC recommends a work RVU of 0.30 for CPT code 93018.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
93015		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report	XXX	0.75 (No Change)
93016		with physician supervision, without interpretation and report	XXX	0.45 (No Change)
93017		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report		
93018		interpretation and report only	XXX	0.30 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93015 Tracking Number Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.75**
Global Period: XXX RUC Recommended RVU: **0.75**

CPT Descriptor: Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55-year-old male with hypertension, active lifestyle, high cholesterol, prior cigarette use with chest discomforts during exercise. His office resting ECG is normal. A stress test is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 5%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work:
- Review medical records and chart
- Answer patient questions for obtaining informed consent
- Determine clinical questions to be answered and appropriateness of study

Description of Intra-Service Work:
- Discuss recent history with the patient
- Examine the patient
- Assess new symptoms since test was ordered
- View resting ECG for adequacy to proceed with stress testing
- Assess pharmacologic stress versus treadmill
- Supervise pharmacologic medication stress infusion if necessary
- Assess adequacy of data collection
- Treat arrhythmias, ischemic responses, hypo- or hypertension, or other untoward medical events
- Treat non cardiac side effects of pharmacologic stress testing
- Interpret multiple serial ECG's for timing, morphology, and degree of ST segment changes and timing of ST segment resolution
- Review and analyze for reporting purposes: starting and ending hemodynamics, arrhythmias, symptoms (especially chest pain), and functional capacity
- Dictate a report for the medical record including whether study is positive, negative , or non-diagnostic for ischemic response

Description of Post-Service Work:

- Review, edit, sign report
- Discuss with patient and/or referring physician any critical results that need to be communicated immediately

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Richard Wright, MD, Bill Van Decker, MD, Diane Wallis, MD				
Specialty(s):	ACC, ASNC, ASE				
CPT Code:	93015				
Sample Size:	515	**Resp N:**	76	**Response:** 14.7 %	
Description of Sample:	random from ACC, ASE, ASNC, and SCMR				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**300.00**	500.00	3000.00
Survey RVW:	0.30	1.00	**1.40**	1.56	4.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	70.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	93015	**Recommended Physician Work RVU: 0.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,040,905

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 30.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 93015**	**Key Reference CPT Code:** 99214	**Source of Time** **RUC Time**
Median Pre-Service Time	2.00	5.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	4.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**26.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.95
Urgency of medical decision making	4.18	3.43
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.09	3.52
Physical effort required	3.00	2.74
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.09
Outcome depends on the skill and judgment of physician	4.27	3.87
Estimated risk of malpractice suit with poor outcome	4.09	3.43

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.36	2.91
Intra-Service intensity/complexity	4.18	3.87
Post-Service intensity/complexity	3.27	3.26

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CMS identified code 93015 for cardiovascular stress test for review in the Physician Fee Schedule Proposed Rule for 2012 because it had not been reviewed since before 2006 and had CY 2010 allowed charges of greater than $10 million at the specialty level. Related codes 93016 and 93018 were also surveyed in compliance with this request. Additionally, CMS identified ECG code 93000 under this logic. That code, and related code 93010, will be reviewed for the October 2012 meeting. We note this because none of these codes—93015, 93016, 93018, 93000, or 93010—were available to be used in the reference service list for this family of codes.

A panel of ACC physicians familiar with the service reviewed the survey data. The response was robust and the survey was completed by physicians who have experience with this service. Survey respondents most frequently compared 93015 to 99214, a level four office visit for an established patient. These respondents indicated 93015 to be slightly more intense/complex in most aspects, with the exception of mental effort related to range of diagnoses and amount/complexity of information to be analyzed. These relationships support the survey median of 1.40, just below the 99214 value of 1.50.

A notable portion of respondents also compared 93015 to 78454, rest or stress planar myocardial perfusion imaging. These respondents found 93015 to be more intense/complex in some areas (6) and less intense/complex in others (5). These relationships again support the survey median of 1.40, just above the 78454 value of 1.34.

The median RVW of 1.40 is higher than the current value of 0.75. Despite the above-mentioned comparisons, the panel does not believe compelling evidence exists for increased valuation and recommends maintaining the current value of 0.75. The panel also recommends the median survey times of 5 minutes preservice, 20 minutes intraservice, and 5 minutes postservice time, updating the current values of 2, 15, and 4, respectively.

For further validation of these recommendations, the panel considered additional comparator codes with similar times and values (see summary spreadsheet). 93294, 92579, 94660, and 93280 have values work values between 0.65 and 0.77 with a range from 4-10 minutes preservice, 15-25 minutes intraservice, and 5-10 minutes postservice time. These comparators further support the recommendation for maintenance of the RVW and updated times.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This code can be reported in tandem with cardiac imaging procedures that require rest and stress elements (stress CT, stress MR, stress SPECT). These studies are typically separate from each other, performed at different times of the day. They are interpreted at different times of the day and in different areas of the facility. They are not typically reported by the same physician, and often are reported by physicians in different groups.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93015

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3200000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on utilization trends in the RUC database, and an estimation that half of these services are provided to the Medicare population.

Specialty cardiology Frequency 2800000 Percentage 87.50 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,600,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on utilization data trends in the RUC database.

Specialty cardiology Frequency 1400000 Percentage 87.50 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93015

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93016 Tracking Number Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55-year-old male with hypertension, active lifestyle, high cholesterol, prior cigarette use with chest discomforts during exercise. His office resting ECG is normal. A stress test is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 9%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work:
- Review medical records and chart
- Answer patient questions for obtaining informed consent
- Determine clinical questions to be answered and appropriateness of study

Description of Intra-Service Work:
- Discuss recent history with the patient
- Examine the patient
- Assess new symptoms since test was ordered
- View resting ECG for adequacy to proceed with stress testing
- Assess pharmacologic stress versus treadmill
- Supervise pharmacologic medication stress infusion if necessary
- Assess adequacy of data collection
- Treat arrhythmias, ischemic responses, hypo- or hypertension, or other untoward medical events
- Treat non cardiac side effects of pharmacologic stress testing

Description of Post-Service Work:
- Document clinical status of patient during stress test
- Discuss with patient and/or referring physician any critical values results that need to be communicated immediately

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Richard Wright, MD, Bill Van Decker, MD, Diane Waliis, MD				
Specialty(s):	ACC, ASNC, ASE				
CPT Code:	93016				
Sample Size:	515	**Resp N:**	53	**Response:** 10.2 %	
Description of Sample:	random from ACC, ASE, ASNC, and SCMR				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**100.00**	300.00	1600.00
Survey RVW:	0.18	0.50	**0.80**	1.23	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**1.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	93016	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,162,922

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,056,063

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 18.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 93016**	**Key Reference CPT Code:** 99213	**Source of Time** **RUC Time**
Median Pre-Service Time	2.00	3.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	2.00	5.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**19.00**	**23.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.11
Urgency of medical decision making	3.90	2.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.80	2.90
Physical effort required	3.00	2.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	2.70
Outcome depends on the skill and judgment of physician	4.00	3.20
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.60	2.90
Intra-Service intensity/complexity	3.90	3.10
Post-Service intensity/complexity	2.40	2.90

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 93016 for supervision of cardiovascular stress test is related to 93015 for cardiovascular stress test, which CMS identified for review in the Physician Fee Schedule Final Rule for 2012.

A panel of ACC physicians familiar with the service reviewed the survey data. The response was robust and the survey was completed by physicians who have experience with this service. Survey respondents most frequently compared 93016 to 99213, a level three office visit for an established patient. These respondents indicated 93016 to be more intense/complex in all aspects except postservice work.

However, selection of a key reference service was diffuse (as shown in the summary spreadsheet), and the survey median of 0.80 is below the 99213 value of 0.97. Nearly as many respondents compared 93016 to 99212, a level two office visit for an established patient. These respondents indicated 93016 to be of greater or equal intensity/complexity in all aspects except postservice work. These relationships support the survey median of 0.80, higher than the 0.48 value for 99212.

Finally, the same number of respondents who selected 99212 also compared 93016 to 93280, dual pacemaker device programming. These respondents indicated 93016 to be more intense/complex in every aspect except postservice work, where it was equal. These relationships again support the survey median of 0.80, just above the 93280 value of 0.77.

The median RVW of 0.80 is higher than the current value of 0.45. Despite the above-mentioned comparisons, the panel does not believe compelling evidence exists for increased valuation and recommends maintaining the current value of 0.45. The panel also recommends the median survey times of 5 minutes preservice, 15 minutes intraservice, and 1.5 minutes postservice time, updating the current values of 10, 38, and 10, respectively. The panel emphasizes that 93016 was last reviewed in 1993, while 93015 and also 93018 were reviewed in 2005. The panel feels this new survey accurately reflects the time required to perform this service.

For validation of these recommendations, the panel considered additional comparator codes with similar times and values (see summary spreadsheet). 93920, 93287, 99201, 96102, and 93268 have work values between 0.43 and 0.52 with a range from 2-5 minutes preservice, 7.5-15 minutes intraservice, and 5-13.5 minutes postservice time. These comparators further support the recommendation for maintenance of the RVW and updated times.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☒ Multiple codes are used to maintain consistency with similar codes.
   ☒ Historical precedents.
   ☒ Other reason (please explain) Physicians often report two of the three codes (93016, 93017,or 93018) depending which aspects of the total service (93015) they provide. These services are temporally separate from each other. They are not typically reported by the same physician, but are likely reported by physicians in the same group. The construction of this family of codes as a technical/professional split means that a provider who provides both of these services is still only reporting the same amount of physician work as the comprehensive code, 93015.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93016

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2200000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on utilization trends in the RUC database, and an estimation that half of these services are provided to the Medicare population.

Specialty cardiology Frequency 1670000 Percentage 75.90 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,100,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on utilization data trends in the RUC database.

Specialty cardiology Frequency 835000 Percentage 75.90 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93016

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93018 Tracking Number Original Specialty Recommended RVU: **0.30**
Presented Recommended RVU: **0.30**
Global Period: XXX RUC Recommended RVU: **0.30**

CPT Descriptor: Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55-year-old male with hypertension, active lifestyle, high cholesterol, prior cigarette use with chest discomforts during exercise. His office resting ECG is normal. A stress test is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 5%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work:
- Review medical records and chart

Description of Intra-Service Work:
- Assess adequacy of data acquisition
- Interpret resting ECG
- Interpret multiple serial ECG's for timing, morphology, and degree of ST segment changes and timing of STsegment resolution
- Review and analyze for reporting purposes: starting and ending hemodynamics, arrhythmias, symptoms (especially chest pain) , and functional capacity
- Dictate a report for the medical record including whether study is positive, negative, or non-diagnostic forischemic response

Description of Post-Service Work:
- Review, edit, sign report
- Discuss with patient and/or referring physician any critical values results that need to be communicated immediately

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012				
Presenter(s):	Richard Wright, MD, Bill Van Decker, MD, Diane Wallis, MD				
Specialty(s):	ACC, ASNC, ASE				
CPT Code:	93018				
Sample Size:	515	**Resp N:**	61	**Response:** 11.8 %	
Description of Sample:	random from ACC, ASE, ASNC, and SCMR				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**200.00**	500.00	2000.00
Survey RVW:	0.13	0.42	**0.60**	1.30	3.50
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	0.00	**7.00**	15.00	60.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	93018	**Recommended Physician Work RVU: 0.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93224	XXX	0.52	**RUC Time**

CPT Descriptor External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.26	**RUC Time**	1,231,612

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
86320	XXX	0.37	**RUC Time**	19,367

CPT Descriptor 2 Immunoelectrophoresis; serum

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 14.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 93018**	**Key Reference CPT Code:** 93224	**Source of Time RUC Time**
Median Pre-Service Time	2.00	2.00	
Median Intra-Service Time	5.00	15.00	
Median Immediate Post-service Time	4.00	7.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**11.00**	**24.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	3.00
Urgency of medical decision making	3.56	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.22	3.38
Physical effort required	1.78	1.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.44	3.00
Outcome depends on the skill and judgment of physician	3.67	3.44
Estimated risk of malpractice suit with poor outcome	3.78	3.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.22	1.89
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	3.22	2.89

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 93018 for interpretation/report of cardiovascular stress test is related to 93015 for cardiovascular stress test, which CMS identified for review in the Physician Fee Schedule Final Rule for 2012.

A panel of ACC physicians familiar with the service reviewed the survey data. The response was robust and the survey was completed by physicians who have experience with this service. Survey respondents most frequently compared 93018 to 93224, review and interpretation of external ECG rhythm recording. These respondents indicated 93018 to be more intense/complex in most aspects, but did feel the intraservice work was equally difficult. This aligns with the survey median of 0.60, slightly higher than the 0.52 value for 93224.

Reference selection was again diffuse (as shown in the summary spreadsheet). The same number of respondents compared 93018 to 78454, rest or stress planar myocardial perfusion imaging. These respondents indicated 93018 to be more intense/complex in all aspects except postservice work.

A large portion also compared 93018 to 93213, a level three office visit for an established patient. These respondents indicated 93018 to be more intense/complex in some aspects (6) and less intense/complex in others (5). Taken together, all of these relationships support the median survey value of 0.60.

The median RVW of 0.60 is higher than the current value of 0.30. Despite the above-mentioned comparisons, the panel does not believe compelling evidence exists for increased valuation and recommends maintaining the current value of 0.30. The panel also recommends the median survey times of 2 minutes preservice, 7 minutes intraservice, and 6 minutes postservice time, updating the current times of 2, 5, and 5, respectively.

For validation of these recommendations, the panel considered additional comparator codes with similar times and values (see summary spreadsheet). 77081, 74020, 93293, and 74022 have work values between 0.22 and 0.32 with a range from 1-5 minutes preservice, 3-10 minutes intraservice, and 1-5 minutes postservice time. These comparators further support the recommendation for maintenance of the RVW and updated times.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☒ Multiple codes are used to maintain consistency with similar codes.
   ☒ Historical precedents.
   ☒ Other reason (please explain) Physicians often report two of the three codes (93016, 93017,or 93018) depending which aspects of the total service (93015) they provide. These services are temporally separate from each other. They are not typically reported by the same physician, but are likely reported by physicians in the same group. The construction of this family of codes as a technical/professional split means that a provider who provides both of these services is still only reporting the same amount of physician work as the comprehensive code, 93015.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93018

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2600000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on utilization trends in the RUC database, and an estimation that half of these services are provided to the Medicare population.

Specialty cardiology Frequency 2106000 Percentage 81.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,300,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on utilization data trends in the RUC database.

Specialty cardiology Frequency 1053000 Percentage 81.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93018

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Cardiovascular Stress Tests

TAB: 48

Year	Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
2006	REF	99214	Level 4 OFFICE/OUTPATIENT VISIT, ESTABLISHED	23	0.047			1.50			40	5					25			10
2005	CURRENT	93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		0.041			0.75			21	2					15			4
	SVY	93015		76	0.059	0.30	1.00	1.40	1.56	4.50	30	5			5	15	20	30	70	5
	REC	93015			0.031			0.75			26	2					20			4

Year	Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
2006	REF	99213	Level 3 OFFICE/OUTPATIENT VISIT, ESTABLISHED	10	0.053			0.97			23	3					15			5
1993	CURRENT	93016	…; physician supervision only, without interpretation and report		0.000			0.45			58	10					38			10
	SVY	93016		53	0.044	0.18	0.50	0.80	1.23	3.00	21.5	5			5	10	15	20	60	1.5
	REC	93016			0.024			0.45			19	2					15			2

Year	Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
2010	REF	93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation	9	0.021			0.52			24	2					15			7
2010	REF	78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	9	0.074			1.34			25	5					15			5
2005	CURRENT	93018	…; interpretation and report only		0.029			0.30			12	2					5			5
	SVY	93018		61	0.060	0.13	0.42	0.60	1.30	3.50	15	2					7			6
	REC	93018			0.033			0.30			11	2					5			4

CPT Code: 93015, 93016, 93018
Specialty Society('s) ACC

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report

93017 tracing only, without interpretation and report

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A cardiology specialty panel discussed the practice expense requirements for the two stress test codes that contain PE and determined that standardized benchmarks for the most common clinical labor practice expenses apply when available (greet/gown, vitals, room preparation, room cleaning). No adjustment was made to the patient preparation time of 8 minutes to account for placement of the 10 leads necessary to secure viable data. Intraservice time was updated to reflect the newly completed survey of 93015, which includes more time-intensive data entry that requires additional data fields. All other times were crosswalked from the existing reference code.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes.

Comparison Code: 93015

Rationale: 93015 was resurveyed. The PE inputs are identical for 93017.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Staff completes pre-service diagnostic and referral forms

Staff schedules stress testing and reviews with patient protocols used regarding need for fasting, medications to be taken or not taken before stress testing, proper clothing for testing, etc.

Service Clinical Labor Activities:

Staff reviews chart and patient clinical information day of test to confirm preparedness of patient for testing and any safety issues

Patient greeting and appropriate gowning for testing

Obtain vital signs

Review procedure protocol with patient, risks and safety concerns and obtain consent

Prepare room, equipment, and supplies

Prepare patient skin with 10 electrodes assuring good electrical contact to eliminate artifact, demonstrate protocol of interacting with treadmill, monitor and other safety concerns

Monitor patient while completing treadmill protocol to acceptable clinical endpoints, including warm up, exercise and cool down

Continue monitoring for protocol completion and until patient returns to baseline

Remove and discard electrodes, assist patient clean up and clean up of equipment and room

Complete stress testing report forms/data entry and gather all clinical information and EKG tracings for physician review and interpretation

Review discharge instructions, stress test results, and coordinate need for future treatments and prescriptions

Post-Service Clinical Labor Activities:

None.

CV stress PE Changes after Practice Expense Subcommittee 04-12

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L051A**	RN	**70.0**	**0.0**	**51.0**	**0.0**	**0.0**	**0.0**	**61.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**15.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**55.0**	**0.0**	**46.0**	**0.0**	**0.0**	**0.0**	**46.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms			**5**		**5**				**5**			
13	Coordinate pre-surgery services			**10**						**10**			
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available			**3**		**3**				**3**			
22	Obtain vital signs			**3**		**3**				**3**			
23	Provide pre-service education/obtain consent			**4**		**4**				**4**			
24	Prepare room, equipment, supplies			**5**		**2**				**2**			
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV			**8**		**5**				**5**			
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure			**14**		**14**				**14**			
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains			**5**		**5**				**5**			
32	Clean room/equipment by physician staff			**3**		**3**				**3**			
33	Clean Scope												
34	Clean Surgical Instrument Package												

CV stress PE Changes after Practice Expense Subcommittee 04-12

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
35	Complete diagnostic forms, lab & X-ray requisitions			**4**		**4**				**4**			

CV stress PE Changes after Practice Expense Subcommittee 04-12

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
36	Review/read X-ray, lab, and pathology reports			**3**		**0**				**0**			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			**3**		**3**				**3**			
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack	**1**		1				1			
57	sandpaper (per sheet)	SK072	item	**1**		1				1			
58	swab-pad, alcohol	SJ053	item	**1**		1				1			
59	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**		0				0			
60	paper, recording (per sheet)	SK059	item	**15**		15				15			
61	electrode, ECG (single)	SD053	item	**10**		10				10			
62	**EQUIPMENT**	**CODE**											
63	cardiac monitor w-treadmill (12-lead PC-based ECG)	EQ078	55	**55**		**58**				**58**			
64	table, exam	EF023	55	**55**		**58**				**58**			
65													

CV stress PE Changes after Practice Expense Subcommittee 04-12

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
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4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L051A**	RN	**70.0**	**0.0**	**57.0**	**0.0**	**0.0**	**0.0**	**53.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**55.0**	**0.0**	**52.0**	**0.0**	**0.0**	**0.0**	**48.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms			**5**		**5**				**5**			
13	Coordinate pre-surgery services			**10**									
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available			**3**		**3**				**3**			
22	Obtain vital signs			**3**		**3**				**3**			
23	Provide pre-service education/obtain consent			**4**		**4**				**4**			
24	Prepare room, equipment, supplies			**5**		**2**				**2**			
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV			**8**		**5**				**5**			
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure			**14**		**20**				**20**			
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains			**5**		**5**				**5**			
32	Clean room/equipment by physician staff			**3**		**3**				**3**			
33	Clean Scope												
34	Clean Surgical Instrument Package												

CV stress PE Changes after Practice Expense Subcommittee 04-12

	A	B	C	D	E	F	G	H	I	J	K	L	M
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4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
35	Complete diagnostic forms, lab & X-ray requisitions			**4**		**4**				**0**			

CV stress PE Changes after Practice Expense Subcommittee 04-12

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
36	Review/read X-ray, lab, and pathology reports			**3**		**0**				**0**			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			**3**		**3**				**3**			
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack	**1**		1				1			
57	sandpaper (per sheet)	SK072	item	**1**		1				1			
58	swab-pad, alcohol	SJ053	item	**1**		1				1			
59	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**		0				0			
60	paper, recording (per sheet)	SK059	item	**15**		15				15			
61	electrode, ECG (single)	SD053	item	**10**		10				10			
62	**EQUIPMENT**	**CODE**											
63	cardiac monitor w-treadmill (12-lead PC-based ECG)	EQ078	55	**55**		**58**				**58**			
64	table, exam	EF023	55	**55**		**58**				**58**			
65													

CV stress PE Changes after Practice Expense Subcommittee 04-12

	1	2	3	4	5	6	7	8	9	10	11	12	13
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L051A**	RN	**70.0**	**0.0**	**53.0**	**0.0**	**0.0**	**0.0**	**63.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**15.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**55.0**	**0.0**	**48.0**	**0.0**	**0.0**	**0.0**	**48.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms			**5**		**5**				**5**			
13	Coordinate pre-surgery services			**10**						**10**			
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - *specify:*												
18	**End: When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters office/facility for surgery/procedure:**												
21	Greet patient, provide gowning, ensure appropriate medical records are available			**3**		**3**				**3**			
22	Obtain vital signs			**3**		**5**				**5**			
23	Provide pre-service education/obtain consent			**4**		**4**				**4**			
24	Prepare room, equipment, supplies			**5**		**2**				**2**			
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV			**8**		**5**				**5**			
27	Sedate/apply anesthesia												
28	**Intra-service**												
29	Assist physician in performing procedure			**14**		**14**				**14**			
30	**Post-Service**												
31	Monitor pt. following service/check tubes, monitors, drains			**5**		**5**				**5**			
32	Clean room/equipment by physician staff			**3**		**3**				**3**			
33	Clean Scope												
34	Clean Surgical Instrument Package												

CV stress PE Changes after Practice Expense Subcommittee 04-12

	1	2	3	4	5	6	7	8	9	10	11	12	13
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
35	Complete diagnostic forms, lab & X-ray requisitions			**4**		**4**				**4**			

CV stress PE Changes after Practice Expense Subcommittee 04-12

	1	2	3	4	5	6	7	8	9	10	11	12	13
1				REFERENCE CODE									
2				93015		93015		93016		93017		93018	
3	**Meeting Date: April 2012** **Tab: Tab 47** **Specialty: ACC**	**CMS Code**	**Staff Type**	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report		…; physician supervision only, without interpretation and report		…; tracing only, without interpretation and report		…; interpretation and report only	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
36	Review/read X-ray, lab, and pathology reports			**3**		**0**				**0**			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			**3**		**3**				**3**			
38	Other Clinical Activity - *specify:*												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
42	**End: Patient leaves office**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**										
56	pack, minimum multi-specialty visit	SA048	pack	**1**		1				1			
57	sandpaper (per sheet)	SK072	item	**1**		1				1			
58	swab-pad, alcohol	SJ053	item	**1**		1				1			
59	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**		0				0			
60	paper, recording (per sheet)	SK059	item	**15**		15				15			
61	electrode, ECG (single)	SD053	item	**10**		10				10			
62	**EQUIPMENT**	**CODE**											
63	cardiac monitor w-treadmill (12-lead PC-based ECG)	EQ078	55	**55**		**58**				**58**			
64	table, exam	EF023	55	**55**		**58**				**58**			
65													

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other - Utilization over 500,000 screen

April 2012

Extremity Studies

In April 2011, CPT codes 93925, 93926, 93970 were identified review by the RUC through the CMS/Other - utilization over 500,000 screen. At the February 2011 RUC meeting, a survey was requested by the Relativity Assessment Workgroup since the codes had "CMS/Other" inputs.

The RUC discussed the compelling evidence that the technology and patient population has changed significantly since the last review of these services. The fundamental physician work for these services has increased due to new technology that was not available in 1995, at the last review. All the arteries below the knee can now be reviewed. In addition, this has led to an increase in the amount of images to be reviewed by the physician. The typical interventions were essentially never performed almost 20 years ago, but are now essential to the procedure. The increased work is also detailed in practice guidelines from accrediting agencies that now show clinical necessity for the additional work of reviewing the tibial arteries. Finally, there has been a change in patient population. The percentage of diabetics has increased in the U.S. since the last review. The typical patient is now a diabetic with heavily calcified vessels which are more complex and take more time to review. The RUC agreed that there is compelling evidence that the physician work has significantly changed since the last valuation.

93925 ***Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study***
The RUC reviewed the survey results from 63 physicians and recommends the median survey physician time components: pre-service time= 5 minutes, intra-service time= 15 minutes, and post-service time= 5 minutes. The RUC agreed that 5 minutes of pre-service time is appropriate to evaluate the patient because an Evaluation and Management service is not typically performed on the same date and same physician. The RUC reviewed the survey respondents' estimated physician work value for this service and agree with the specialty that 0.90 work RVU, the survey median, accurately values this service. To justify this value, the RUC reviewed the key reference service 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* (work RVU= 1.30) and agreed that while the physician work is similar, the reference code should be valued higher due to greater intra-service time, 20 minutes compared to 15 minutes. In addition, the RUC reviewed CPT code 92012 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient* (work RVU= 0.92) and noted that the two service have analogous physician work and identical time components. Given this, the two services should be valued similarly. Finally the RUC reviewed CPT code 73700 *Computed tomography, lower extremity; without contrast material* (work RVU= 1.00) and agreed that the two services should be valued similarly, given the analogous physician work and time components. **The RUC recommends a work RVU of 0.90 for CPT code 93925.**

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93926 ***Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study***
The RUC reviewed the survey results from 59 physicians and recommends the median survey physician time components: pre-service time= 5 minutes, intra-service time= 10 minutes, and post-service time= 5 minutes. The RUC agreed that 5 minutes of pre-service time is appropriate to evaluate the patient because a Evaluation and Management service is not typically performed on the same date and same physician. The RUC reviewed the survey respondents' estimated physician work value for this service and agree with the specialty that 0.70 work RVU, the survey median, accurately values this service. To justify this value, the RUC reviewed the key reference code 76776 *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU= 0.76) and agreed that the two services have identical physician time components and both describe the same spectrum of work. Given this, the surveyed code is correctly valued similar to 76776. In addition, the RUC compared 93926 to reference code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU= 0.75) and agree that because the two services employ the same technology and have almost identical physician time components, the two service should be valued similarly. **The RUC recommends a work RVU of 0.70 for CPT code 93926.**

93970 ***Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study***
The RUC reviewed the survey results from 53 physicians and recommends the median survey physician time components: pre-service time= 3 minutes, intra-service time= 15 minutes, and post-service time= 5 minutes. The RUC agreed that 3 minutes of pre-service time is appropriate to evaluate the patient because a Evaluation and Management service is not typically performed on the same date and same physician. The RUC reviewed the survey respondents' estimated physician work value for this service and agree with the specialty that 0.70 work RVU, the survey median, accurately values this service. To justify this value, the RUC compared 93970 to key reference code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* (work RVU= 0.45) and agreed that while the physician work is comparable, the surveyed code should be valued higher due to greater intra-service time compared to the reference code, 15 minutes and 10 minutes, respectively. In addition, the RUC reviewed CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and noted that while the surveyed code has five more minutes of intra-service time, 76700 is a more intense procedure and should be valued higher than 93970. **The RUC recommends a work RVU of 0.70 for CPT code 93970.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
93925		Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	XXX	0.90
93926		unilateral or limited study	XXX	0.70
93970		Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	XXX	0.70

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93925 Tracking Number Original Specialty Recommended RVU: **0.90**
Presented Recommended RVU: **0.90**
Global Period: XXX RUC Recommended RVU: **0.90**

CPT Descriptor: Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old diabetic smoker has bilateral lifestyle-limiting lower extremity intermittent claudication unresponsive to maximal medical therapy. A duplex scan is ordered to determine if percutaneous intervention is possible. A complete bilateral duplex scan of the femoral, popliteal, and tibial arteries is performed

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review the noninvasive diagnostic test requisition form, noting the patient's medical history, risk factors and clinical history providing the indication for the examination. Review previous diagnostic studies for the patient that may be used for comparative surveillance or to diagnose disease progression.

Description of Intra-Service Work: Supervise technologist identification of the arterial structures of both lower extremities; including the common femoral, profunda femoris, superficial femoral, popliteal, tibial-peroneal trunk, anterior tibial, posterior tibial and peroneal arteries. Examine recordings of B-mode images, angle-corrected Doppler velocity spectra and colorflow imaging in all standard locations, per protocol. Evaluate additional specific Doppler velocities, B-mode images and colorflow data provided from identified areas of stenosis, including data from pre-stenotic, intra-stenotic and post-stenotic regions of the affected arteries. Ensure that all Doppler velocity spectra have been accurately angle-corrected. Estimate severity of stenosis based on angiographically-determined grading scales. Synthesize final interpretation, taking into account all available data to estimate severity of stenosis, impact of sequential stenoses, calcification, and collateralization. Render interpretation indicating the severity, location, and length of the arterial occlusive disease and/or insufficiency in the involved segments. Provide comparison to previous studies, when prior results are available. Identify etiology of the patient's arterial disease. Dictate report.

Description of Post-Service Work: Reviewed and sign report. Send copy of report to the referring physician and/or primary care provider. Archive study. Provide a verbal report of critical results directly to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Geraldine McGinty, MD, Zeke Silva, MD and Richard Wright, MD		
Specialty(s):	Vascular Surgery, Radiology and Cardiology		
CPT Code:	93925		
Sample Size:	3231	**Resp N:** 63	**Response:** 1.9 %
Description of Sample:	SVS - 1953, All US, MD members ACR - 942, randomly selected ACC - 336, randomly selected		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	40.00	**100.00**	200.00	1500.00
Survey RVW:	0.45	0.80	**0.90**	1.20	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**15.00**	17.00	75.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	93925	**Recommended Physician Work RVU: 0.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93306	XXX	1.30	**RUC Time**

CPT Descriptor Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,040,905

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92012	XXX	0.92	**RUC Time**	6,697,588

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 26.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 93925**	**Key Reference CPT Code:** 93306	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	5.00	7.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**25.00**	**32.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.29
Urgency of medical decision making	3.24	3.41
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.76	3.59
Physical effort required	2.71	2.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.24	3.47
Outcome depends on the skill and judgment of physician	3.94	3.65
Estimated risk of malpractice suit with poor outcome	3.29	3.35

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.63
Intra-Service intensity/complexity	3.71	3.71
Post-Service intensity/complexity	2.94	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

Code 93925 was among 24 codes identified by CMS and for which review by the RUC was requested based on low RVUs and utilization greater than 500,000. At the February 2011 RUC meeting, survey was requested by the RAW since the code had "CMS/Other" inputs.

Compelling Evidence

There is compelling evidence that the work of 93925 has changed since this code was presented at the First Five-Year Review in 1995. Accrediting bodies have established detailed practice guidelines for this procedure recommending study components that were not performed when this very old CPT code was created. Additional work now includes extensive colorflow ultrasound assessment of below-knee popliteal, tib-peroneal trunk, and tibial arteries searching for angioplasty, atherectomy and endovascular stent sites. These are interventions that were essentially never done in any significant volume 25 years ago but are very common now, and providers ordering these exams expect accurate anatomic delineation of their status. Colorflow technology did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate tibial arteries when 93925 was initially created. Compared to review of static images printed on x-ray film, new archiving technology on video screens provides for the interpretation of more images, more sophisticated velocity waveforms, and the post-processing of the acquired data.

Comparison with Key Reference Service 93306

Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

93306 was presented at the RUC in April 2007 and has a work RVU of 1.30. 93306, providing ultrasound and colorflow diagnostics of the heart, describes the same modalities of physician work as 93925. 93306 and 93925 share the same pre-service time of 5 minutes. 93306 has 2 additional minutes of immediate post-service times, compared to 93925. Importantly, 93306 has five additional minutes of intra time, and this 25% intra time difference accounts for the lower recommended median survey RVW of 0.90 for 93925, compared to the RVW of 1.30 for the key reference service. Considered from a pure mathematical relationship, the 15/20 intra-time relationship would support a value of 0.75 x 1.30 = 0.98 for 93925, and the small differences in post-service time account for the difference. Thus, the comparison with key reference 93306 fully supports the median survey value of 0.90 for 93925.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
93306	1.30	0.052	32	5	20	7
93925	0.90	0.045	25	5	15	5

Comparison with E&M Service 99213

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99213 was presented at the Third Five-Year Review in February 2006. It has a work RVU of 0.97. The physician time required for interpretation of B-mode ultrasound images, color-flow images and Doppler spectra in 93925 differ only by two minutes of pre time compared to the time involved in 99213. Both codes have identical intra-times of 15 minutes. Based on this comparison, the median survey value of 0.90 for 93925 is appropriate.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post

99213	0.97	0.053	23	3	15	5
93925	0.90	0.045	25	5	15	5

Comparison with Extremity CT scan 73700
Computed tomography, lower extremity; without contrast material

73700 was presented at the RUC in October 2009 and has a work RVU of 1.00. Comparison of the clinical services indicates that 73700 represents an examination of one lower extremity while 93925 is a complete bilateral exam. The physician time required for interpretation of B-mode ultrasound images, color-flow images and Doppler spectra in 93925 are exactly the same as the time involved in the CT code 73700. Both codes have identical physician work intra times of 15 minutes. Based on this comparison, the median survey value of 0.90 for 93925 is justified.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
73700	1.00	0.052	25	5	15	5
93925	0.90	0.045	25	5	15	5

Conclusion: For this code we provided three comparisons. The first relates 93925 to a similar diagnostic test modality, echocardiography. The second compares 93925 to a cognitive service (99213) while the third comparison represents an assessment of the same body part by two different diagnostic testing modalities. In each case, the comparison supports the median survey value of 0.90 for this complete bilateral arterial duplex exam. We believe the three-way comparison strengthens the justification for 0.90 even more.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93925

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Vascular Surgery How often? Commonly

Specialty Radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
586,176 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare Data

Specialty Cardiology Frequency 181715 Percentage 31.00 %

Specialty Vascular Surgery Frequency 82065 Percentage 14.00 %

Specialty Radiology Frequency 52756 Percentage 9.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93925

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93926 Tracking Number Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: XXX RUC Recommended RVU: **0.70**

CPT Descriptor: Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old diabetic smoker has left lower extremity intermittent claudication unresponsive to maximal medical therapy. A duplex scan is ordered to determine if percutaneous intervention is possible. A unilateral duplex scan of the femoral, popliteal, and tibial arteries is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review the noninvasive diagnostic test requisition form, noting the patient's medical history, risk factors and clinical history providing the indication for the examination. Review previous diagnostic studies for the patient that may be used for comparative surveillance or to diagnose disease progression.

Description of Intra-Service Work: Supervise technologist identification of the arterial structures of the lower extremity; including the common femoral, profunda femoris, superficial femoral, popliteal, tibial-peroneal trunk, anterior tibial, posterior tibial and peroneal arteries. Examine recordings of B-mode images, angle-corrected Doppler velocity spectra and colorflow imaging in all standard locations, per protocol. Evaluate additional specific Doppler velocities, B-mode images and colorflow data provided from identified areas of stenosis, including data from pre-stenotic, intra-stenotic and post-stenotic regions of the affected arteries. Ensure that all Doppler velocity spectra have been accurately angle-corrected. Estimate severity of stenosis based on angiographically-determined grading scales. Synthesize final interpretation, taking into account all available data to estimate severity of stenosis, impact of sequential stenoses, calcification, and collateralization. Render interpretation indicating the severity, location, and length of the arterial occlusive disease and/or insufficiency in the involved segments. Provide comparison to previous studies, when prior results are available. Identify etiology of the patient's arterial disease. Dictate report.

Description of Post-Service Work: Reviewed and sign report. Send copy of report to the referring physician and/or primary care provider. Archive study. Provide a verbal report of critical results directly to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Geraldine McGinty, MD, Zeke Silva, MD and Richard Wright, MD		
Specialty(s):	Vascular Surgery, Radiology and Cardiology		
CPT Code:	93926		
Sample Size:	3231	**Resp N:** 59	**Response:** 1.8 %
Description of Sample:	SVS - 1953, All US, MD members ACR - 942, randomly selected ACC - 336, randomly selected		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	30.00	**75.00**	145.00	2000.00
Survey RVW:	0.39	0.50	**0.70**	0.81	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**10.00**	15.00	65.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	93926	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76776	XXX	0.76	**RUC Time**

CPT Descriptor Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,040,905

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 16.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 93926**	**Key Reference CPT Code:** 76776	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	3.50
Urgency of medical decision making	3.00	3.10
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.60
Physical effort required	2.60	2.70
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.50	2.70
Outcome depends on the skill and judgment of physician	3.60	3.70
Estimated risk of malpractice suit with poor outcome	2.60	2.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.70
Intra-Service intensity/complexity	3.00	3.10
Post-Service intensity/complexity	2.70	2.80

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background
Code 93926 was among 24 codes identified by CMS and for which review by the RUC was requested based on low RVUs and utilization greater than 500,000. At the February 2011 RUC meeting, survey was requested by the RAW since the code had "CMS/Other" inputs.

Compelling Evidence
There is compelling evidence that the work of 93926 has changed since this code was presented at the First Five-Year Review in 1995. Accrediting bodies have established detailed practice guidelines for this procedure recommending study components that were not performed when this very old CPT code was created. Additional work now includes extensive colorflow ultrasound assessment of below-knee popliteal, tib-peroneal trunk, and tibial arteries searching for angioplasty, atherectomy and endovascular stent sites. These are interventions that were essentially never done in any significant volume 25 years ago but are very common now, and providers ordering these exams expect accurate anatomic delineation of their status. Colorflow technology did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate tibial arteries when 93926 was initially created. Compared to review of static images printed on x-ray film, new archiving technology on video screens provides for the interpretation of more images, more sophisticated velocity waveforms, and the post-processing of the acquired data.

Comparison with Key Reference Service 76776
Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation

76776 was presented at the RUC in September 2005 and has a work RVU of 0.76. 76776, providing ultrasound and colorflow diagnostics of transplanted kidney, describes the same spectrum of physician work as 93926. 76776 has identical pre-service, intraservice and immediate post-service times as 93926. Based on this comparison, the median survey value of 0.70 for 93926 is justified.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
76776	0.76	0.054	20	5	10	5
93926	0.70	0.048	20	5	10	5

Comparison with E&M Service 99231
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99231 was presented at the Third Five-Year Review in February of 2006 and has a work RVU of 0.76. The physician time required for interpretation of B-mode ultrasound images, color-flow images and Doppler spectra in 93926 is exactly the same as that involved in E&M code 99231. Both codes have a physician intra time of 10 minutes. Based on this comparison, the survey median value of 0.70 for 93925 is justified.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
99231	0.76	0.054	20	5	10	5
93926	0.70	0.048	20	5	10	5

Comparison with Blood flow ultrasound code 76817

Ultrasound, pregnant uterus, real time with image documentation, transvaginal

76817 was presented at the RUC in April 2002 and has a work RVU of 0.75. 76817 employs the same technology as 93926, albeit with a different ultrasound transducer than 93925. 76817 and 93925 have the same pre-service time of 5 minutes, and exactly the same intra-service time of 10 minutes. 76817 has three more minutes of immediate post-service time (8 minutes vs. 5 minutes). Overall, this comprises an excellent relativity comparison and serves to justify the median survey value of 0.70 for 93926

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
76817	0.75	0.046	32	5	10	8
93926	0.70	0.048	20	5	10	5

Conclusion: In this additional rationale we provide comparisons of 93926 arterial duplex ultrasound to a key reference exam, which is an ultrasound of another body part, and to an E&M cognitive service, and finally to a second RUC-surveyed ultrasound code. In each case, the survey median of 0.70 is well justified based on service components, physician time, and procedural intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93926

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery How often? Commonly

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 209,208 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare Data

Specialty Vascular Surgery	Frequency 104604	Percentage 50.00 %
Specialty Cardiology	Frequency 33474	Percentage 16.00 %
Specialty Radiology	Frequency 12553	Percentage 6.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93926

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93970 Tracking Number Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: XXX RUC Recommended RVU: **0.70**

CPT Descriptor: Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old woman with lung cancer and a prior history of lower extremity deep venous thrombosis presents with new onset bilateral lower extremity pain and swelling. A bilateral venous duplex ultrasound is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review the noninvasive diagnostic test requisition form, noting the patient's medical history, risk factors and clinical history providing the indication for the examination. Review previous diagnostic studies for the patient that may be used for comparative surveillance or to diagnose disease progression.

Description of Intra-Service Work: Supervise technologist identification of the venous structures of both lower extremities; including the common femoral, superficial femoral, popliteal, tibial-peroneal trunk(s), paired peroneal veins, paired posterior tibial veins, greater saphenous, and lesser saphenous. Document presence and direction of flow within each of these veins as well as compressibility, respiratory variation and response to augmentation. When thrombus is present, describe echogenicity vs. echolucency. Describe whether thrombus is fully occlusive or non-occlusive. Evaluate and characterize incidental perivascular anatomic structures including adjacent lymphadenopathy, soft tissue edema, or soft tissue collections such as hematoma or abscess, or synovial cysts such as popliteal (Baker's) cysts. Render interpretation indicating the severity and chronicity of the venous occlusive disease in the involved venous segments. Provide comparison to previous studies when prior results are available. Comment on etiology of the patient's venous disease. Dictate report.

Description of Post-Service Work: Reviewed and sign report. Send copy of report to the referring physician and/or primary care provider. Archive the study. Provide a verbal report of critical results, such as acute deep venous thrombosis, to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, Mathew Sideman, MD, Michael Sutherland, MD, Sean Roddy, MD, Geraldine McGinty, MD, Zeke Silva, MD and Richard Wright, MD		
Specialty(s):	Vascular Surgery, Radiology and Cardiology		
CPT Code:	93970		
Sample Size:	3231	**Resp N:** 53	**Response:** 1.6 %
Description of Sample:	SVS - 1953, All US, MD members ACR - 942, randomly selected ACC - 336, randomly selected		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	75.00	**200.00**	500.00	3000.00
Survey RVW:	0.45	0.60	**0.70**	0.97	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	15.00	75.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	93970	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93971	XXX	0.45	**RUC Time**

CPT Descriptor Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,706,082

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,040,905

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 28.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 93970**	**Key Reference CPT Code:** 93971	**Source of Time** **RUC Time**
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	15.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**23.00**	**18.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.87	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.57
Urgency of medical decision making	3.20	2.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.93	3.07
Physical effort required	2.07	2.14
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.60	2.50
Outcome depends on the skill and judgment of physician	3.20	3.14
Estimated risk of malpractice suit with poor outcome	3.07	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.53	2.47
Intra-Service intensity/complexity	2.80	2.60
Post-Service intensity/complexity	2.60	2.53

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

Code 93970 was among 24 codes identified by CMS and for which review by the RUC was requested based on low RVUs and utilization greater than 500,000. At the February 2011 RUC meeting, survey was requested by the RAW since the code had "CMS/Other" inputs.

Compelling Evidence

There is compelling evidence that the work of 93970 has changed since this code was presented at the First Five-Year Review in 1995. Accrediting bodies (eg ICAVL, ACR) have established detailed practice guidelines for this procedure recommending study components that were not performed when this very old CPT code was created. Additional work now includes colorflow ultrasound assessment and compression ultrasonography of tibial-peroneal trunk veins, posterior tibial veins and peroneal veins. Colorflow technology did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate calf veins when 93970 was initially created, so this is all new. Compared to review of static images printed on x-ray film, new archiving technology on video screens provides for the interpretation of more images, more sophisticated velocity waveforms with precise time assessments, and the post-processing of the acquired data.

Comparison with Key Reference Service 93971

Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

93971 was presented at the RUC in April 2011 and has a work RVU of 0.45. 93971, providing interpretation of a *single* limb lower extremity venous duplex exam, describes the same spectrum of physician work as 93970, but twice as many images, color-flows and Doppler spectra are reviewed in the bilateral study. The two services have the identical pre-service and immediate post-service times. 93970, the complete bilateral study, has five additional minutes of intra time and the 33% intra time difference correlates with the recommended median survey RVW of 0.70 compared to the RVW of 0.45 for the key reference service.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
93971	0.45	0.027	18	3	10	5
93970	0.70	0.033	23	3	15	5

Comparison with E&M Service 99213

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99213 was presented at the Third Five-Year Review in April of 2006. It has a work RVU of 0.97. The physician pre-, intra-, and post-service times required for interpretation of B-mode ultrasound images, color-flow images and Doppler spectra in 93970 are identical to the time involved in E&M code 99213. 99213 has a work RVU of 0.97, and we are recommending the median survey RVU of 0.70 for 92970, or 0.27 lower RVU than the E&M service. Since the times are exactly the same, this 0.27 RVU difference must reflect a slightly lower intensity of diagnostic exam compared to that of the face-to-face E&M, and we believe that to be the case. Nevertheless, a reduction below the median survey value of 0.70 for 93970 would overtly disrupt the relativity between 93970 and 99213.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
99213	0.97	0.053	23	3	15	5

93970	0.70	0.033	23	3	15	5

Comparison with MPC CPT Code 76700
Ultrasound, abdominal, real time with image documentation; complete

76700, an MPC CPT Code, was presented to the RUC at the Third Five-Year Review in August 2005. It has a work RVU of 0.81. The intra-time for 76700 is 10 minutes compared to 15 minutes for 93970. Pre times are equal at 5 minutes, and the physician post-service times differ by one minute (table). Both tests involve interpretation of ultrasound diagnostic information. Comparing the relativity of physician work for this high volume MPC code, the median survey value of 0.70 for 93970 is justified.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
76700	0.81	0.065	17	3	10	4
93970	0.70	0.033	23	3	15	5

Conclusion: In this rationale, we compared the recommended work RVU of bilateral complete venous duplex ultrasound, 93970, to that of a clinically similar, RUC-reviewed ultrasound blood flow study (93971). We also compared 93970 to a cognitive service (99213), and we compared it to a similar diagnostic ultrasound exam on the MPC list (76700). When considered independently, each of these comparisons provides a strong justification for the median survey RVW of 0.70, but when one considers that these three comparisons include one same-modality service, one purely cognitive service and one complimentary modality service, it is difficult to think that the work RVU for this code could be anything other than 0.70.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93970

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery How often? Commonly

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,599,899 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare Data

Specialty Vascular Surgery Frequency 287982 Percentage 18.00 %

Specialty Cardiology Frequency 271983 Percentage 17.00 %

Specialty Radiology Frequency 239985 Percentage 15.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93970

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Extremity Studies
TAB: 36

SOURCE	CPT	DESC	N	Resp	%	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	POST P-SD	SURVEY EXPERIENCE MIN	SURVEY 25th	SURVEY MED	SURVEY 75th	SURVEY MAX	TYP
REF	93306	Echocardiography, transthoracic, real-time with im	63	17	27%	0.052			1.30			32	5			20			7						
CMS/OTH	93925	Duplex scan of lower extremity arteries or arter							0.58			18													
SVY	93925	Duplex scan of lower extremity arteries or arter	3231	63	2%	0.045	0.45	0.80	0.90	1.20	3.00	25	5	0	10	15	17	75	5	2	40	100	200	1500	87%
REC						0.045			0.90			25	5			15			5						
REF	76776	Ultrasound, transplanted kidney, real time and dup	59	10	17%	0.054			0.76			20	5			10			5						
CMS/OTH	93926	Duplex scan of lower extremity arteries or arter							0.39			14													
SVY	93926	Duplex scan of lower extremity arteries or arter	3231	59	1%	0.048	0.39	0.50	0.70	0.81	2.00	20	5	0	5	10	15	65	5	2	30	75	145	2000	85%
REC						0.048			0.70			20	5			10			5						
REF	93971	Duplex scan of extremity veins including response	53	15	28%	0.027			0.45			18	3			10			5						
CMS/OTH	93970	Duplex scan of extremity veins including respo							0.68			20													
SVY	93970	Duplex scan of extremity veins including respo	3231	53	1%	0.032	0.45	0.60	0.70	0.97	2.00	25	5	2	10	15	15	75	5	0	75	200	500	3000	92%
REC						0.035			0.70			23	3			15			5						
Apr-2011	93971	unilateral / limited study (veins)				0.027			0.45			18	3			10			5						

CPT Code: 93925, 93926, 93970 and 93971
Specialty Society('s) SVS, ACR and ACC

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

- 93925 *Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study*
- 93926 *Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study*
- 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study*
- 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study*

Global Period: XXX **Meeting Date:** 04/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The multispecialty organizations (SVS, ACR and ACC) convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these procedures.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

A reference code was not included in these recommendations because they are existing codes. We included the current direct PE inputs for reference.

Please describe in detail the clinical activities of your staff:

CPT Codes 93925, 93926, 93970 and 93971

Pre-Service Clinical Labor Activities:
Retrieve prior imaging exams, labs and pathology reports. Hang for MD review, verify orders, review chart to incorporate relevant clinical information.

Post-Service Clinical Labor Activities:
Documentation

93925 ***Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study***

Intra-Service Clinical Labor Activities:
The technologist/sonographer/examiner should introduce him/herself and explain why the complete bilateral lower extremity arterial duplex examination is being performed and explain the procedure to the patient. In addition, respond to questions and concerns about any aspect of the examination. Patient assessment must be performed before the duplex exam is started. This includes assessment of the patient's ability to tolerate the procedure and an evaluation of any contra-indications to the procedure. The technologist/sonographer/examiner should **o**btain a pertinent history and review the patient's medical record.

Throughout each exam, sonographic characteristics of normal and abnormal tissues, structures, and blood flow must be observed so that scanning technique can be adjusted as necessary to optimize image quality and spectral waveform characteristics. The patient's physical and mental status is assessed and monitored during the examination, and modifications are made to the procedure plan according to changes in the patient's clinical condition during the procedure. Sonographic findings are analyzed throughout the course of the examination to ensure that sufficient data is provided to the physician to direct patient management and render a final diagnosis.

The standard exam includes multiple acoustic windows and patient positioning techniques with complete bilateral assessment of the following vessels in their entirety: common femoral, profunda femoris, superficial femoral, popliteal, anterior tibial, posterior tibial, and peroneal arteries. Evidence of plaque formation within the vessel lumen, wall calcification or dilatation should be documented. Doppler spectral analysis is used to quantify disease severity and should include assessment for presence or absence of flow. When flow is present, evaluation will include peak systolic velocity, end diastolic velocity, and waveform analysis [e.g., systolic upstroke / acceleration, pulsatility, spectral broadening, turbulence and flow direction]. At a minimum, spectral analysis should be obtained in all vessel segments as well as proximal, throughout and distal to any region where flow disturbance is identified. All Doppler derived velocity information must be performed at an angle of 60 degrees or less with respect to the direction of blood flow, and Doppler cursor alignment is recommended parallel to the vessel walls.

Anatomic variants should be documented. Areas of stenosis will be assessed with attention to pre-stenotic, stenotic and post-stenotic Doppler waveform analysis. Data are reviewed to ensure that a complete and comprehensive evaluation has been performed and documented. All technical findings required to complete the final interpretation are recorded on a worksheet, logbook or within a PACS data collection system so that the findings can be classified according to the laboratory's diagnostic criteria based on published or internally validated data.

Documentation includes date, clinical indication(s), technologist performing the exam, and the exam summary in a vascular laboratory log book or other appropriate method, i.e., computer software. The technologist/sonographer assembles preliminary results as provided by internal guidelines.

93926 ***Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study***

Intra-Service Clinical Labor Activities:
The technologist/sonographer/examiner should introduce him/herself and explain why the complete bilateral lower extremity arterial duplex examination is being performed and explain the procedure to the patient. In addition, respond to questions and concerns about any aspect of the examination. Patient assessment must be performed before the duplex exam is started. This includes assessment of the patient's ability to tolerate the procedure and an evaluation of any contra-indications to the procedure. The technologist/sonographer/examiner should **o**btain a pertinent history and review the patient's medical record.

Throughout each exam, sonographic characteristics of normal and abnormal tissues, structures, and blood flow must be observed so that scanning technique can be adjusted as necessary to optimize image quality and spectral waveform characteristics. The patient's physical and mental status is assessed and monitored during the examination, and modifications are made to the procedure plan according to changes in the patient's clinical condition during the procedure. Sonographic findings are analyzed throughout the course of the examination to ensure that sufficient data is provided to the physician to direct patient management and render a final diagnosis.

The standard exam includes multiple acoustic windows and patient positioning techniques with unilateral or limited assessment of the following vessels in their entirety: common femoral, profunda femoris, superficial femoral, popliteal, anterior tibial, posterior tibial, and peroneal arteries. Evidence of plaque formation within the vessel lumen, wall calcification or dilatation should be documented. Doppler spectral analysis is used to quantify disease severity and should include assessment for presence or absence of flow. When flow is present, evaluation will include peak systolic velocity, end diastolic velocity, and waveform analysis [e.g., systolic upstroke / acceleration, pulsatility, spectral broadening, turbulence and flow direction]. At a minimum, spectral analysis should be obtained in all vessel segments as well as proximal, throughout and distal to any region where flow disturbance is identified. All Doppler derived velocity information must be performed at an angle of 60 degrees or less with respect to the direction of blood flow, and Doppler cursor alignment is recommended parallel to the vessel walls.

Anatomic variants should be documented. Areas of stenosis will be assessed with attention to pre-stenotic, stenotic and post-stenotic Doppler waveform analysis. Data are reviewed to ensure that a complete and comprehensive evaluation has been performed and documented. All technical findings required to complete the final interpretation are recorded on a worksheet, logbook or within a PACS data collection system so that the findings can be classified according to the laboratory's diagnostic criteria based on published or internally validated data.

Documentation includes date, clinical indication(s), technologist performing the exam, and the exam summary in a vascular laboratory log book or other appropriate method, i.e., computer software. The technologist/sonographer assembles preliminary results as provided by internal guidelines.

93970 ***Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study***

Intra-Service Clinical Labor Activities:
Throughout each exam, sonographic characteristics of normal and abnormal tissues, structures, and blood flow are continually observed. The patient's physical and mental status are assessed and monitored during the examination. Modifications may be made to the procedure plan according to changes in the patient's clinical status. Also, sonographic findings are analyzed throughout the course of the examination to ensure that sufficient data is provided to render a final diagnosis.

The examination is performed with the patient in the supine position and the head of the bed elevated approximately 12 inches with the leg externally rotated slightly. This is the position of choice for viewing the common femoral vein (CFV), femoral vein (FV), deep femoral vein, (DFV), great saphenous vein (GSV), popliteal vein, and posterior tibial veins, (PTV). Reverse Trendelenburg may be used as an alternate position. The patient may be turned prone or to the lateral decubitus position to view the popliteal vein, peroneal and proximal posterior tibial veins, small saphenous vein and soleal veins. Positioning the patient slightly to the opposite side which is being evaluated, when pregnant or if abnormal CFV signals are present may normalize the side in question.

Use appropriate duplex instrumentation with appropriate frequencies for the vessels being examined. This includes display of both two-dimensional structure and motion in real-time and Doppler ultrasonic signal documentation with spectral analysis with or without color Doppler imaging, videotape, film or digital storage of static images and/or cineloop.

A complete bilateral venous duplex evaluation performs the following on both lower extremities. The study incorporates both B-mode and color Doppler imaging along with Doppler spectral analysis. The common femoral, deep femoral (origin), femoral, popliteal, posterior tibial, peroneal, and great saphenous veins should be interrogated in their entirety. In select cases, and when indicated, the small saphenous, gastrocnemius branches, soleal, anterior tibial and perforating veins are examined. Transverse transducer compressions must be performed every 2 cms or less and representative images are obtained per lab protocol. Typically samples are taken at the proximal CFV, saphenofemoral junction, proximal femoral vein, mid or distal femoral vein, popliteal and at the mid/distal PTV. Compression of the peroneal veins should be documented at the mid/distal calf as well.

When pathology (thrombus or intraluminal echoes) is present, compressibility, appearance, location, and extent should be documented. The B-Mode image should demonstrate the degree of compressibility, presence of intraluminal echoes, and dilation to assist in describing characteristic of aging the thrombus. The technologist should differentiate between brightly echogenic or hypoechoic thrombi, partially or totally non-compressible segments, and between unattached proximal tips and attached thrombi. Spectral and/or color Doppler are used to further support the diagnosis and to document spectral waveform profiles. A representative Doppler spectral waveform should be obtained from the same levels as noted above for documentation of compression: i.e. common femoral, femoral, popliteal segments. The posterior tibial and peroneal veins are evaluated for flow using color Doppler, preferable on a transverse view. .Doppler spectral analysis is performed in the sagittal plane, with an appropriate vessel

angle. It is not required to angle correct, however, if angle correction is utilized, it must be at 60 degrees or less and aligned with the vessel wall. To accurately assess venous waveform profiles, flow is characterized according to its spontaneity, phasicity, and the presence of brisk augmented venous flow with proximal or distal augmentation. To ensure complete interrogation, spectral waveforms are performed while utilizing proximal or distal compression of the limb to demonstrate augmentation.

Incidental findings, such as Baker's Cyst, seroma, hematoma, lymph node, mass, etc. must be reported. Characterization of such findings should include measurements of size and/or presence of blood flow.
All information collected during the study is organized and archived. Each image and Doppler spectrum is double-checked to ensure accuracy and completeness of labeling. Preliminary technical findings are synthesized for assessment by the interpreting physician.

93971 ***Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study***

Intra-Service Clinical Labor Activities:
Throughout each exam, sonographic characteristics of normal and abnormal tissues, structures, and blood flow are continually observed. The patient's physical and mental status are assessed and monitored during the examination. Modifications may be made to the procedure plan according to changes in the patient's clinical status. Also, sonographic findings are analyzed throughout the course of the examination to ensure that sufficient data is provided to render a final diagnosis.

The examination is performed with the patient in the supine position and the head of the bed elevated approximately 12 inches with the leg externally rotated slightly. This is the position of choice for viewing the common femoral vein (CFV), femoral vein (FV), deep femoral vein, (DFV), great saphenous vein (GSV), popliteal vein, and posterior tibial veins, (PTV). Reverse Trendelenburg may be used as an alternate position. The patient may be turned prone or to the lateral decubitus position to view the popliteal vein, peroneal and proximal posterior tibial veins, small saphenous vein and soleal veins. Positioning the patient slightly to the opposite side which is being evaluated, when pregnant or if abnormal CFV signals are present may normalize the side in question.

Use appropriate duplex instrumentation with appropriate frequencies for the vessels being examined. This includes display of both two-dimensional structure and motion in real-time and Doppler ultrasonic signal documentation with spectral analysis with or without color Doppler imaging, videotape, film or digital storage of static images and/or cineloop.

A complete unilateral venous duplex evaluation incorporates both B-mode and color Doppler imaging along with Doppler spectral analysis. The common femoral, deep femoral (origin), femoral, popliteal, posterior tibial, peroneal, and great saphenous veins should be interrogated in their entirety. In select cases, and when indicated, the small saphenous, gastrocnemius branches, soleal, anterior tibial and perforating veins are examined. Transverse transducer compressions must be performed every 2 cms or less and representative images are obtained per lab protocol. Typically samples are taken at the proximal CFV, saphenofemoral junction, proximal femoral

vein, mid or distal femoral vein, popliteal and at the mid/distal PTV. Compression of the peroneal veins should be documented at the mid/distal calf as well.

When pathology (thrombus or intraluminal echoes) is present, compressibility, appearance, location, and extent should be documented. The B-Mode image should demonstrate the degree of compressibility, presence of intraluminal echoes, and dilation to assist in describing characteristic of aging the thrombus. The technologist should differentiate between brightly echogenic or hypoechoic thrombi, partially or totally non-compressible segments, and between unattached proximal tips and attached thrombi. Spectral and/or color Doppler are used to further support the diagnosis and to document spectral waveform profiles. A representative Doppler spectral waveform should be obtained from the same levels as noted above for documentation of compression: i.e. common femoral, femoral, popliteal segments. The posterior tibial and peroneal veins are evaluated for flow using color Doppler, preferable on a transverse view. .Doppler spectral analysis is performed in the sagittal plane, with an appropriate vessel angle. It is not required to angle correct, however, if angle correction is utilized, it must be at 60 degrees or less and aligned with the vessel wall. To accurately assess venous waveform profiles, flow is characterized according to its spontaneity, phasicity, and the presence of brisk augmented venous flow with proximal or distal augmentation. To ensure complete interrogation, spectral waveforms are performed while utilizing proximal or distal compression of the limb to demonstrate augmentation.

Incidental findings, such as Baker's Cyst, seroma, hematoma, lymph node, mass, etc. must be reported. Characterization of such findings should include measurements of size and/or presence of blood flow.
All information collected during the study is organized and archived. Each image and Doppler spectrum is double-checked to ensure accuracy and completeness of labeling. Preliminary technical findings are synthesized for assessment by the interpreting physician.

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			CURRENT	CURRENT			CURRENT	CURRENT		
2				93926TC PEAC 2002	93971TC PEAC 2002	93926TC	93971TC	93925TC PEAC 2002	93970TC PEAC 2002	93925TC	93970TC
3	**Meeting Date: April 2012** **Tab: 35** **Specialty: SVS, ACR and ACC**	**CMS Code**	**Staff Type**	**Unilateral or limited** - Duplex scan of lower extremity arteries or	**Unilateral or limited** - Duplex scan of extremity veins including	**Unilateral or limited** - Duplex scan of lower extremity arteries or arterial bypass	**Unilateral or limited** - Duplex scan of extremity veins including responses to	**Complete bilateral** - Duplex scan of lower extremity arteries or	**Complete bilateral** - Duplex scan of extremity veins including	**Complete bilateral** - Duplex scan of lower extremity arteries or arterial bypass	**Complete bilateral** - Duplex scan of extremity veins including responses to
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L054A	Vascular Tech	**74**	**57**	**54**	**42**	**110**	**86**	**88**	**64**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L054A	Vascular Tech	**63**	**48**	**51**	**39**	**99**	**75**	**85**	**61**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L054A	Vascular Tech	**8**	**6**	**0**	**0**	**8**	**8**	**0**	**0**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
17	**Other Clinical Activity***: Review/read prior vascular lab studies, x-ray, lab, and pathology reports*			**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L054A	Vascular Tech	**4**	**3**	**3**	**3**	**4**	**3**	**3**	**3**
22	Obtain vital signs	L054A	Vascular Tech	**3**	**3**			**3**	**3**		
23	Provide pre-service education/obtain consent	L054A	Vascular Tech	**3**	**3**	**2**	**2**	**3**	**4**	**2**	**2**
24	Prepare room, equipment, supplies	L054A	Vascular Tech	**3**	**3**	**2**	**2**	**3**	**3**	**2**	**2**
25	Prepare and position patient	L054A	Vascular Tech	**3**	**3**	**2**	**2**	**3**	**3**	**2**	**2**
26	**Intra-service**										
27	Aquire images	L054A	Vascular Tech	**35**	**23**	**35**	**23**	**69**	**45**	**66**	**42**
28	**Post-Service**										
29	Clean room/equipment by physician staff	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
30	**Other Clinical Activity:** *Collate preliminary data, arrange images, archive*	L054A	Vascular Tech	**8**	**6**	**4**	**4**	**10**	**10**	**7**	**7**
31	**Other Clinical Activity***: Record patient history*	L054A	Vascular Tech	**1**	**1**	**0**	**0**	**1**	**1**	**0**	**0**
35	**End: Patient leaves office**										
36	**POST-SERVICE Period**										
37	**Start: Patient leaves office/facility**										
38	Phone calls, faxes, emails between visits with ordering physician, patient, family	L054A	Vascular Tech	**4**	**3**			**4**	**4**		
46	**Other Clinical Activity***: QA documentation*	L054A	Vascular Tech	**4**	**3**	**0**	**0**	**4**	**4**	**0**	**0**
47	**End: with last office visit before end of global period**										

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			CURRENT	CURRENT			CURRENT	CURRENT		
2				93926TC PEAC 2002	93971TC PEAC 2002	93926TC	93971TC	93925TC PEAC 2002	93970TC PEAC 2002	93925TC	93970TC
3	**Meeting Date: April 2012** **Tab: 35** **Specialty: SVS, ACR and ACC**	**CMS Code**	**Staff Type**	**Unilateral or limited** - Duplex scan of lower extremity arteries or	**Unilateral or limited** - Duplex scan of extremity veins including	**Unilateral or limited** - Duplex scan of lower extremity arteries or arterial bypass	**Unilateral or limited** - Duplex scan of extremity veins including responses to	**Complete bilateral** - Duplex scan of lower extremity arteries or	**Complete bilateral** - Duplex scan of extremity veins including	**Complete bilateral** - Duplex scan of lower extremity arteries or arterial bypass	**Complete bilateral** - Duplex scan of extremity veins including responses to
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
48	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
49	pack, minimum multi-specialty visit	SA048	pack	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
50	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**	**2**	**1**	**2**	**1**	**1**	**1**	**1**
51	cover-condom, transducer or ultrasound probe	SB005	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
52	ultrasound transmission gel	SJ062	ml	**30**	**40**	**30**	**40**	**50**	**60**	**50**	**60**
53	film, 8inx10in (ultrasound, MRI)	SK022	item	**2**	**2**	**2**	**2**	**3**	**3**	**3**	**3**
54	film, x-ray 14in x 17in	SK034	item	**1**	**1**	**1**	**1**	**2**	**2**	**2**	**2**
55	patient education booklet	SK062	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
56	video tape, VHS	SK086	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
57	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**
58	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**
59	**EQUIPMENT**	**CODE**									
60	room, ultrasound, vascular	EL016		**63**	**38**	**59**	**45**	**99**	**75**	**95**	**71**
61	computer, desktop, w-monitor	ED021		**63**	**38**	**59**	**45**	**99**	**75**	**95**	**71**
62	stretcher	EF018		**63**	**38**			**99**	**75**		
63	video SVHS VCR (medical grade)	ED034		**63**	**38**	**59**	**45**	**99**	**75**	**95**	**71**
64	film processor, wet	ED025		**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
65	video printer, color (Sony medical grade)	ED036		**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
66	x-ray view box, 4 panel	ER067		**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
67	computer system, record and verify	ED011				**10**	**10**			**10**	**10**

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			CURRENT	CURRENT			CURRENT	CURRENT		
2				93926TC PEAC 2002	93971TC PEAC 2002	93926TC	93971TC	93925TC PEAC 2002	93970TC PEAC 2002	93925TC	93970TC
3	**Meeting Date: April 2012** **Tab: 35** **Specialty: SVS, ACR and ACC**	**CMS Code**	**Staff Type**	**Unilateral or limited** - Duplex scan of lower extremity arteries or	**Unilateral or limited** - Duplex scan of extremity veins including	**Unilateral or limited** - Duplex scan of lower extremity arteries or arterial bypass	**Unilateral or limited** - Duplex scan of extremity veins including responses to	**Complete bilateral** - Duplex scan of lower extremity arteries or	**Complete bilateral** - Duplex scan of extremity veins including	**Complete bilateral** - Duplex scan of lower extremity arteries or arterial bypass	**Complete bilateral** - Duplex scan of extremity veins including responses to
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
6	**TOTAL CLINICAL LABOR TIME**	L054A	Vascular Tech	**74**	**57**	**66**	**52**	**110**	**86**	**102**	**78**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L054A	Vascular Tech	**63**	**48**	**59**	**45**	**99**	**75**	**95**	**71**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	L054A	Vascular Tech	**8**	**6**	**4**	**4**	**8**	**8**	**4**	**4**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
17	**Other Clinical Activity***: Review/read prior vascular lab studies, x-ray, lab, and pathology reports*			**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L054A	Vascular Tech	**4**	**3**	**3**	**3**	**4**	**3**	**3**	**3**
22	Obtain vital signs	L054A	Vascular Tech	**3**	**3**			**3**	**3**		
23	Provide pre-service education/obtain consent	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**4**	**3**	**3**
24	Prepare room, equipment, supplies	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
25	Prepare and position patient	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
26	**Intra-service**										
27	Aquire images	L054A	Vascular Tech	**35**	**23**	**35**	**23**	**69**	**45**	**69**	**45**
28	**Post-Service**										
29	Clean room/equipment by physician staff	L054A	Vascular Tech	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
30	**Other Clinical Activity:** *Collate preliminary data, arrange images, archive*	L054A	Vascular Tech	**8**	**6**	**8**	**6**	**10**	**10**	**10**	**10**
31	**Other Clinical Activity***: Record patient history*	L054A	Vascular Tech	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
35	**End: Patient leaves office**										
36	**POST-SERVICE Period**										
37	**Start: Patient leaves office/facility**										
38	Phone calls, faxes, emails between visits with ordering physician, patient, family	L054A	Vascular Tech	**4**	**3**			**4**	**4**		
46	**Other Clinical Activity***: QA documentation*	L054A	Vascular Tech	**4**	**3**	**4**	**4**	**4**	**4**	**4**	**4**
47	**End: with last office visit before end of global period**										

	A	B	C	D	E	F	G	H	I	J	K
1	REVISED			CURRENT	CURRENT			CURRENT	CURRENT		
2				93926TC PEAC 2002	93971TC PEAC 2002	93926TC	93971TC	93925TC PEAC 2002	93970TC PEAC 2002	93925TC	93970TC
3	**Meeting Date: April 2012** **Tab: 35** **Specialty: SVS, ACR and ACC**	**CMS Code**	**Staff Type**	**Unilateral or limited** - Duplex scan of lower extremity arteries or	**Unilateral or limited** - Duplex scan of extremity veins including	**Unilateral or limited** - Duplex scan of lower extremity arteries or arterial bypass	**Unilateral or limited** - Duplex scan of extremity veins including responses to	**Complete bilateral** - Duplex scan of lower extremity arteries or	**Complete bilateral** - Duplex scan of extremity veins including	**Complete bilateral** - Duplex scan of lower extremity arteries or arterial bypass	**Complete bilateral** - Duplex scan of extremity veins including responses to
4	**LOCATION**			**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
5	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
48	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
49	pack, minimum multi-specialty visit	SA048	pack	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
50	drape, non-sterile, sheet 40in x 60in	SB006	item	**1**	**2**	**1**	**2**	**1**	**1**	**1**	**1**
51	cover-condom, transducer or ultrasound probe	SB005	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
52	ultrasound transmission gel	SJ062	ml	**30**	**40**	**30**	**40**	**50**	**60**	**50**	**60**
53	film, 8inx10in (ultrasound, MRI)	SK022	item	**2**	**2**	**2**	**2**	**3**	**3**	**3**	**3**
54	film, x-ray 14in x 17in	SK034	item	**1**	**1**	**1**	**1**	**2**	**2**	**2**	**2**
55	patient education booklet	SK062	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
56	video tape, VHS	SK086	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
57	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**	**0.34**
58	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**
59	**EQUIPMENT**	**CODE**									
60	room, ultrasound, vascular	EL016		**63**	**38**	**59**	**45**	**99**	**75**	**95**	**71**
61	computer, desktop, w-monitor	ED021		**63**	**38**	**59**	**45**	**99**	**75**	**95**	**71**
62	stretcher	EF018		**63**	**38**			**99**	**75**		
63	video SVHS VCR (medical grade)	ED034		**63**	**38**	**59**	**45**	**99**	**75**	**95**	**71**
64	film processor, wet	ED025		**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
65	video printer, color (Sony medical grade)	ED036		**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
66	x-ray view box, 4 panel	ER067		**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
67	computer system, record and verify	ED011				**10**	**10**			**10**	**10**

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedure Codes

April 2012

Immunotherapy Injections-PE Only

This service was identified by CMS in July 2011 through the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC noted that this service has not been reviewed in the last 6 years and recommended the practice expense be reviewed for the family of services at the April 2012 meeting. The time for administration of injections was reduced from 2 minutes to 1 minute for 1 injection and 4 minutes to 2 minutes for 2 or more injections. **The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95115		Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	XXX	0.00 (PE Input Recommendations Only)
95117		Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	XXX	0.00 (PE Input Recommendations Only)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117 2 or more injections

Global Period: XXX **Meeting Date:** April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Joint Council of Allergy, Asthma and Immunology and American Academy of Otolaryngic Allergy convened a consensus group of ten physicians (five from each organization). The group met by conference call and developed its recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

We have provided three reference codes: Code 90471 describes a very similar service (immunization administration through percutaneous, intradermal, subcutaneous, or intramuscular injection) and has very similar practice expense details compared with 95115 and 95117. The main differences are that 90471 has physician work RVUs and 95115 and 95117 do not. Additionally, 90471 will typically be billed with an E/M service, while 95115 and 95117 are typically not billed with an E/M service. We also provide the previously approved direct expense inputs for 95115 and 95117 as references for the current recommendation. We note that these codes are being reviewed at the request of CMS because 95117 was identified as a high-volume code and it has not been reviewed since 2002. There have been no changes to the code descriptors.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
N/A

Service Clinical Labor Activities:
Clinical staff retrieves the patient chart; determines dosage for injection; greets patient; takes brief history including current medications; responds to patient questions since last injection; obtains consent; retrieves patient's immunotherapy vial, confirms with patient, and documents correct vial / correct patient; prepares injection for administration; positions patient for injection and cleans injection site; administers injection; checks injection site and monitors patient intermittently; discusses possibility of delayed reaction with patient; reaffirms that patient understands how to recognize a reaction and what to do if a reaction occurs; determines schedule for next injection; and cleans room.

Post-Service Clinical Labor Activities:
N/A

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**REVISED 4-25-12**			**Add'l Crosswalk Jan 2008**		**REFERENCE CODE PEAC Sep-02**		**RECOMMEND**		**REFERENCE CODE PEAC Sep-02**		**RECOMMEND**		
2				**90471**		**95115**		**95115**		**95117**		**95117**		
3	**Meeting Date: April 2012 Tab: 48 Specialty: JCAAI, AAOA**	**CMS Code**	**Staff Type**	Immunization administration (includes percutaneous,		Professional services for allergen immunotherapy		Professional services for allergen immunotherapy		Professional services for allergen immunotherapy		Professional services for allergen immunotherapy		**NOTES**
4	**LOCATION**			**NF**	**FAC**	**NF**	**FAC**	**NF**	**FAC**	**NF**	**FAC**	**NF**	**FAC**	
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**XXX**	**XXX**	**000**	**000**	**XXX**	**XXX**	
6	**TOTAL CLINICAL LABOR TIME**			**17**	**0**	**16**	**0**	**15**	**0**	**19**	**0**	**17**	**0**	
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**17**	**0**	**15**	**0**	**15**	**0**	**18**	**0**	**17**	**0**	
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	
10	**PRE-SERVICE**													
11	**Start: Following visit when decision for surgery or procedure made**													
18	**End: When patient enters office/facility for surgery/procedure**													
19	**SERVICE PERIOD**													
20	**Start: When patient enters office/facility for surgery/procedure:**													
21	Review charts, interval history	L037D	RN/LPN/MTA	**1**		**2**				**2**				
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA			**1**		**3**		**1**		**3**		Standard. [Not typically billed with EM. Do not have physician work RVUs.]
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**		**2**		**2**		**2**		**2**		Review immunotherapy process with patient, including possibility of a reaction. Respond to questions since last visit. Obtain consent.
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**		**2**		**2**		**3**		**3**		95115: standard 2 min to prepare room plus one injection - consistent with 90471. 95117: std 2 min plus one additional minute for preparation of additional injections from separate vials.
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			**1**		**1**		**1**		**1**		One minute (1/2 of std 2 min). Patients may receive injections in various anatomic locations requiring specific positioning. Patients may also require a topical anesthetic prior to injection (eg, children).
29	**Intra-service**													
30	Perform Procedure	L037D	RN/LPN/MTA	**2**		**2**		**1**		**4**		**2**		**CHANGED TO 1 MIN PER INJECTION**
31	**Post-Service**													
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	**3**		**2**		**2**		**2**		**2**		Previously approved time to monitor patient for reaction.
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		While cleaning room, staff will continue to monitor pt.
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**1**		**0**		**1**		**0**		**1**		Discuss possibility of delayed reaction. Reaffirm that patient understands how to recognize a reaction and what to do if a reaction occurs.
39	Other Clinical Activity - *specify:* *Record vaccine information*			**2**										
40	**End: Patient leaves office**													
41	**POST-SERVICE Period**													
42	**Start: Patient leaves office/facility**													
43	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			**1**		**0**		**1**		**0**		
55	**End: with last office visit before end of global period**													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
2				**90471**		**95115**		**95115**		**95117**		**95117**		
3	**Meeting Date: April 2012** **Tab: 48** **Specialty: JCAAI, AAOA**	**CMS Code**	**Staff Type**	Immunization administration (includes percutaneous,		Professional services for allergen immunotherapy		Professional services for allergen immunotherapy		Professional services for allergen immunotherapy		Professional services for allergen immunotherapy		**NOTES**
4	**LOCATION**			**NF**	**FAC**	**NF**	**FAC**	**NF**	**FAC**	**NF**	**FAC**	**NF**	**FAC**	
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**											
57	Paper, exam table	SB036	feet					**7**		**0**		**7**		typically not billed with EM
58	gloves, non-sterile	SB022	pair	**1**		**2**		**1**		**2**		**1**		
59	swab-pad, alcohol	SJ053	item	**2**		**2**		**2**		**4**		**4**		one pad to draw each injection. one pad to cleanse each injection site.
60	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	**1**		**1**		**1**		**2**		**2**		one per injection
61	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**1**		**1**		**1**		**2**		**2**		one per injection site
62	CDC information sheet	SK012	item	**1**		**0**		**0**		**0**		**0**		
63	**EQUIPMENT**	**CODE**												
64	light, exam	EQ168		**0**				**15**				**17**		= total service period
65	exam table	EF023		**13**				**15**				**17**		= total service period
66	refrigerator, vaccine, commercial grade, w-alarm lock	EF040		**17**				**15**				**17**		= total service period
67	refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates	ED043		**17**				**0**				**0**		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Re-Review Families of New/Revised Codes screen

April 2012

Evoked Potentials and Reflex Studies-PE Only

These services were most recently identified in the Nov 28, 2011 Final Rule for 2012. CMS requested that the RUC re-review specific codes in a family of services that were recently reviewed. In January 2012, the RUC reviewed the CMS identified family of services and recommended that codes 95925 and 95926 be referred to the PE Subcommittee to review in April 2012 to determine if any practice expense anomalies exist between 95938 or 95939 and these codes. The RUC determined that review of physician work is not necessary at this time. Practice expense inputs were revised to align with accepted standards and the intra-service time for *Assist the physician in performing procedure* was revised to reflect the typical time needed when a patient is being tested for one limb as compared to two limbs. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95925		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs (Do not report 95925 in conjunction with 95926)	XXX	0.54 (PE Input Recommendations Only)
95926		in lower limbs (Do not report 95926 in conjunction with 95925)	XXX	0.54 (PE Input Recommendations Only)
95938		in upper and lower limbs (Do not report 95938 in conjunction with 95925, 95926)	XXX	0.86 (PE Input Recommendations Only)

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95928		Central motor evoked potential study (transcranial motor stimulation); upper limbs (Do not report 95928 in conjunction with 95929)	XXX	1.50 (PE Input Recommendations Only)
95929		lower limbs (Do not report 95929 in conjunction with 95928)	XXX	1.50 (PE Input Recommendations Only)
95939		in upper and lower limbs (Do not report 95939 in conjunction with 95928, 95929)	XXX	2.25 (PE Input Recommendations Only)

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CPT Code: 95925
Specialty Societies: AAN, AANEM, ACNS, AAPMR

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

95925 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 4 surveying specialties met and communicated via email via to develop recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for special needs, e.g. anxiolytic requirements, sleep deprivation, bring pain medicines or sleep medicines. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer medication.

Intra-Service Clinical Labor Activities:

Prepare room, supplies, and equipment. Greet and gown patient. Take history and perform brief exam. Establish patient testing strategy. Explain procedure. Contact supervising physician for special needs or problems. Have patient go to bathroom. Position the patient in a comfortable chair. Calibrate machine and set chosen testing parameters. Assist physician in conducting the test. Coach patient to relax better or fall asleep, despite electric shocks. Test first limb, requiring 500-1000 trials of stimulation, excluding trials with muscle contamination. Repeat testing on first limb two or three times. Repeat procedure for second limb. Remove electrodes and clean up patient, including carefully removing electrode gel from hair. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Clean and sterilize electrodes. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

CPT Code: 95926
Specialty Societies: AAN, AANEM, ACNS, AAPMR

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

95926 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 4 surveying specialties met and communicated via email via to develop recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for special needs, e.g. anxiolytic requirements, sleep deprivation, bring pain medicines or sleep medicines. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer medication.

Intra-Service Clinical Labor Activities:

Prepare room, supplies, and equipment. Greet and gown patient. Take history and perform brief exam. Establish patient testing strategy. Explain procedure. Contact supervising physician for special needs or problems. Have patient go to bathroom. Position the patient in a comfortable chair. Calibrate machine and set chosen testing parameters. Assist physician in conducting the test. Coach patient to relax better or fall asleep, despite electric shocks. Test first limb, requiring 500-1000 trials of stimulation, excluding trials with muscle contamination. Repeat testing on first limb two or three times. Repeat procedure for second limb. Remove electrodes and clean up patient, including carefully removing electrode gel from hair. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Clean and sterilize electrodes. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

95928 Central motor evoked potential study (transcranial motor stimulation); in upper limbs

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from the surveying specialties met and communicated via email to develop recommendations.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Review requisition. Assess for contraindications. e.g. implanted devices, skull defects, history of seizures. Assess for confounding factors, e.g. diabetes, peripheral neuropathy, known neuromuscular disorders. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer any medication.

Intra-Service Clinical Labor Activities:

Prepare room, supplies, and equipment. Greet and gown patient. Take history and perform brief exam or head and limbs. Establish patient testing strategy. Explain procedure. Review with supervising physician for special needs or problems. Position the patient on a comfortable exam table. Assist physician in conducting the test. Together, place electrodes in correct muscles and identify best places to try first as stimulation sites. Coach the patient to relax better despite the brain stimulation. Coach the patient to improve the test by slightly contracting muscle being tested. Test the first muscle in the first limb, requiring series of stimulation trials, excluding trials with muscle contamination. Continue trials with slight variations in stimulation site and stimulus intensity. Identify the optimal stimulus sites and intensity for best motor responses. Repeat testing on first muscle in the first limb two or three times. Repeat the procedure with the stimulator moved to the spine. Repeat the procedure with the stimulator moved over the plexus. Measure distances among the stimulation sites and recording site. Repeat the three-site procedure for the second and the third muscles on the first limb. Repeat that whole procedure for second limb. Remove electrodes and clean up patient. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

95929 Central motor evoked potential study (transcranial motor stimulation); in lower limbs

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from the surveying specialties met and communicated via email to develop recommendations.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Review requisition. Assess for contraindications. e.g. implanted devices, skull defects, history of seizures. Assess for confounding factors, e.g. diabetes, peripheral neuropathy, known neuromuscular disorders. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer any medication.

Intra-Service Clinical Labor Activities:

Prepare room, supplies, and equipment. Greet and gown patient. Take history and perform brief exam or head and limbs. Establish patient testing strategy. Explain procedure. Review with supervising physician for special needs or problems. Position the patient on a comfortable exam table. Assist physician in conducting the test. Together, place electrodes in correct muscles and identify best places to try first as stimulation sites. Coach the patient to relax better despite the brain stimulation. Coach the patient to improve the test by slightly contracting muscle being tested. Test the first muscle in the first limb, requiring series of stimulation trials, excluding trials with muscle contamination. Continue trials with slight variations in stimulation site and stimulus intensity. Identify the optimal stimulus sites and intensity for best motor responses. Repeat testing on first muscle in the first limb two or three times. Repeat the procedure with the stimulator moved to the spine. Repeat the procedure with the stimulator moved over the plexus. Measure distances among the stimulation sites and recording site. Repeat the three-site procedure for the second and the third muscles on the first limb. Repeat that whole procedure for second limb. Remove electrodes and clean up patient. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

95938 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs

(Do not report 95938 in conjunction with 95925, 95926)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from each of the 4 surveying specialties met and communicated via email via to develop recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for special needs, e.g. anxiolytic requirements, sleep deprivation, bring pain medicines or sleep medicines. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer medication.

Intra-Service Clinical Labor Activities:

Prepare room, supplies, and equipment. Greet and gown patient. Take history and perform brief exam. Establish patient testing strategy. Explain procedure. Contact supervising physician for special needs or problems. Have patient go to bathroom. Position the patient in a comfortable chair. Calibrate machine and set chosen testing parameters. Assist physician in conducting the test. Coach patient to relax better or fall asleep, despite electric shocks. Test first limb, requiring 500-1000 trials of stimulation, excluding trials with muscle contamination. Repeat testing on first limb two or three times. Repeat procedure for second limb. Give patient a bathroom break and short timeout. Repeat procedure for third limb. Repeat procedure for fourth limb. Remove electrodes and clean up patient, including carefully removing electrode gel from hair. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Clean and sterilize electrodes. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

95939 Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs

(Do not report 95939 in conjunction with 95928, 95929)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel representing members from the surveying specialties met and communicated via email and developed recommendations.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

We provided the PE inputs for 95939 that were approved in April 2011 RUC meeting.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Review requisition. Assess for contraindications. e.g. implanted devices, skull defects, history of seizures. Assess for confounding factors, e.g. diabetes, peripheral neuropathy, known neuromuscular disorders. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer any medication.

Intra-Service Clinical Labor Activities:

Prepare room, supplies, and equipment. Greet and gown patient. Take history and perform brief exam or head and limbs. Establish patient testing strategy. Explain procedure. Review with supervising physician for special needs or problems. Position the patient on a comfortable exam table. Assist physician in conducting the test. Together, place electrodes in correct muscles and identify best places to try first as stimulation sites. Coach the patient to relax better despite the brain stimulation. Coach the patient to improve the test by slightly contracting muscle being tested. Test the first muscle in the first limb, requiring series of stimulation trials, excluding trials with muscle contamination. Continue trials with slight variations in stimulation site and stimulus intensity. Identify the optimal stimulus sites and intensity for best motor responses. Repeat testing on first muscle in the first limb two or three times. Repeat the procedure with the stimulator moved to the spine. Repeat the procedure with the stimulator moved over the plexus. Measure distances among the stimulation sites and recording site. Repeat the three-site procedure for the second and the third muscles on the first limb. Repeat that whole procedure for second limb. Repeat procedure for third limb. Repeat procedure for fourth limb. Remove electrodes and clean up patient. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			Recommended		Reference		Recommended		Reference		Recommended		Reference	
2				**95925**		**95925**		**95926**		**95926**		**95938**		**95938**	
3	**Meeting Date: April 2012** **Tab: 50** **Specialty: AAN, AANEM, AAPMR, ACNS**	**CMS Code**	**Staff Type**	SEP, upper limbs		SEP, upper limbs		SEP, lower limbs		SEP, lower limbs		SEP, both upper & lower limbs		SEP, both upper & lower limbs	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**	**L047B**	**REEGT**												
6	**TOTAL CLINICAL LABOR TIME**	**L047B**	**REEGT**	**84.0**	**0.0**	**87.0**	**0.0**	**84.0**	**0.0**	**87.0**	**0.0**	**140.0**	**0.0**	**140.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L047B**	**REEGT**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L047B**	**REEGT**	**76.0**	**0.0**	**76.0**	**0.0**	**76.0**	**0.0**	**76.0**	**0.0**	**132.0**	**0.0**	**129.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L047B**	**REEGT**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	**L047B**	**REEGT**	**2**				**2**				**2**		**2**	
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - *specify: Review requisition. Assess for special needs. Give patient instructions for test preparation (eg, hair lotion) and what to expect on the day of testing.*	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
21	Greet patient, provide gowning, ensure appropriate medical records are available	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
22	Obtain vital signs														
23	Provide pre-service education/obtain consent														
24	Prepare room, equipment, supplies	**L047B**	**REEGT**	**2**				**2**				**2**		**2**	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV														
27	Sedate/apply anesthesia														
28	**Intra-service**														
29	Assist physician in performing procedure	**L047B**	**REEGT**	**65**				**65**				**121**		**121**	
30	**Post-Service**														
31	Monitor pt. following service/check tubes, monitors, drains	**L047B**	**REEGT**												
32	Clean room/equipment by physician staff	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions	**L047B**	**REEGT**	**3**				**3**				**3**			
36	Review/read X-ray, lab, and pathology reports														
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			Recommended		Reference		Recommended		Reference		Recommended		Reference	
2				**95925**		**95925**		**95926**		**95926**		**95938**		**95938**	
3	**Meeting Date: April 2012** **Tab: 50** **Specialty: AAN, AANEM, AAPMR, ACNS**	**CMS Code**	**Staff Type**	SEP, upper limbs		SEP, upper limbs		SEP, lower limbs		SEP, lower limbs		SEP, both upper & lower limbs		SEP, both upper & lower limbs	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**	**L047B**	**REEGT**												
45	Conduct phone calls/call in prescriptions													**3**	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REVISED			Recommended		Reference		Recommended		Reference		Recommended		Reference	
2				**95925**		**95925**		**95926**		**95926**		**95938**		**95938**	
3	**Meeting Date: April 2012** **Tab: 50** **Specialty: AAN, AANEM, AAPMR, ACNS**	**CMS Code**	**Staff Type**	SEP, upper limbs		SEP, upper limbs		SEP, lower limbs		SEP, lower limbs		SEP, both upper & lower limbs		SEP, both upper & lower limbs	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**	**L047B**	**REEGT**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack	**1**		**1**		**1**		**1**		**1**		**1**	
57	Electrode, EEG (single)	SD165		**8**		**8**		**8**		**8**		**16**		**16**	
58	colodian (2 oz)	SJ014		**1**		**1**		**1**		**1**		**1**		**1**	
59	gauze, sterile 4 in X 4 in (10 pack)	SG056		**1**		**1**		**1**		**1**		**2**		**2**	
60	electrode, skin prep gel (NuPrep)	SJ022		**10**		**10**		**10**		**10**		**20**		**20**	
61	electrode, ground	SD059		**1**		**1**		**1**		**1**		**1**		**1**	
62	tape, porous-hypoallergenic 2 in (Scanpore)	SG077		**24**		**24**		**24**		**24**		**48**		**48**	
63	paper, recording (per sheet)	SK059		**6**		**6**		**6**		**6**		**12**		**12**	
64	needle, blunt tip	SC034		**1**		**1**		**1**		**1**		**1**		**1**	
65	drape, non sterile, sheet 40in x 60 in	SB006		**1**		**1**		**1**		**1**		**1**		**1**	
66	acetone	SL001		**7**		**15**		**7**		**15**		**15**		**15**	
67	syringe 3ml	SC055		**1**		**1**		**1**		**1**		**1**		**1**	
68	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018		**0.17**		**0.34**		**0.17**		**0.34**		**0.34**		**0.34**	
69	measuring tape, paper	SK048		**1**		**1**		**1**		**1**		**1**		**1**	
70	swab-pad, alcohol	SJ053		**2**		**2**		**2**		**2**		**4**		**4**	
71	electrode conductive gel	SJ020		**1**		**1**		**1**		**1**		**2**		**2**	
72	Emory board	SK021													
73															
74	**EQUIPMENT**	**CODE**													
75	EMG-NCV-EP system, 8 channel	EQ024		**76**		**76**		**76**		**76**		**132**		**129**	
76	Table, Exam	EF023		**76**		**76**		**76**		**76**		**132**		**129**	
77	air compressor, safety	EQ047		**76**		**76**		**76**		**76**		**132**		**129**	
78	magnetic stimulator system (BiStim)	EQ180													
79	magnetic stimulator hand coil (70-90mm)	EQ178													
80	magnetic stimulator leg coil (110mm)	EQ179													
81	printer, laser, paper	ED032													
82															

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			Recommended		Reference		Recommended		Reference		Recommended		Reference	
2				95928		95928		95929		95929		95939		95939	
3	**Meeting Date: April 2012 Tab: 50 Specialty: AAN, AANEM, AAPMR, ACNS**	**CMS Code**	**Staff Type**	MEP, upper limbs		MEP, upper limbs		MEP, lower limbs		MEP, lower limbs		MEP, both upper & lower limbs		MEP, both upper & lower limbs	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**	**L047B**	**REEGT**												
6	**TOTAL CLINICAL LABOR TIME**	**L047B**	**REEGT**	**94.0**	**0.0**	**92.5**	**0.0**	**94.0**	**0.0**	**92.5**	**0.0**	**161.0**	**0.0**	**158.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L047B**	**REEGT**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L047B**	**REEGT**	**86.0**	**0.0**	**84.5**	**0.0**	**86.0**	**0.0**	**84.5**	**0.0**	**153.0**	**0.0**	**150.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L047B**	**REEGT**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	**L047B**	**REEGT**	**2**				**2**				**2**		**2**	
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - *specify: Review requisition. Assess for special needs. Give patient instructions for test preparation (eg, hair lotion) and what to expect on the day of testing.*	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
21	Greet patient, provide gowning, ensure appropriate medical records are available	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
22	Obtain vital signs														
23	Provide pre-service education/obtain consent														
24	Prepare room, equipment, supplies	**L047B**	**REEGT**	**2**				**2**				**2**		**2**	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV														
27	Sedate/apply anesthesia														
28	**Intra-service**														
29	Assist physician in performing procedure	**L047B**	**REEGT**	**75**				**75**				**142**		**142**	
30	**Post-Service**														
31	Monitor pt. following service/check tubes, monitors, drains	**L047B**	**REEGT**												
32	Clean room/equipment by physician staff	**L047B**	**REEGT**	**3**				**3**				**3**		**3**	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions	**L047B**	**REEGT**	**3**				**3**				**3**			
36	Review/read X-ray, lab, and pathology reports														
42	**End: Patient leaves office**														
43	**POST-SERVICE Period**														
44	**Start: Patient leaves office/facility**														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			Recommended		Reference		Recommended		Reference		Recommended		Reference	
2				**95928**		**95928**		**95929**		**95929**		**95939**		**95939**	
3	**Meeting Date: April 2012** **Tab: 50** **Specialty: AAN, AANEM, AAPMR, ACNS**	**CMS Code**	**Staff Type**	MEP, upper limbs		MEP, upper limbs		MEP, lower limbs		MEP, lower limbs		MEP, both upper & lower limbs		MEP, both upper & lower limbs	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**	**L047B**	**REEGT**												
45	Conduct phone calls/call in prescriptions														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	REVISED			Recommended		Reference		Recommended		Reference		Recommended		Reference	
2				95928		95928		95929		95929		95939		95939	
3	**Meeting Date: April 2012** **Tab: 50** **Specialty: AAN, AANEM, AAPMR, ACNS**	**CMS Code**	**Staff Type**	MEP, upper limbs		MEP, upper limbs		MEP, lower limbs		MEP, lower limbs		MEP, both upper & lower limbs		MEP, both upper & lower limbs	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**	**L047B**	**REEGT**												
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**												
56	pack, minimum multi-specialty visit	SA048	pack	**1**		**1**		**1**		**1**		**1**		**1**	
57	Electrode, EEG (single)	SD165		**12**		**12**		**12**		**12**		**24**		**24**	
58	colodian (2 oz)	SJ014													
59	gauze, sterile 4 in X 4 in (10 pack)	SG056		**1**		**1**		**1**		**1**		**2**		**2**	
60	electrode, skin prep gel (NuPrep)	SJ022		**2**		**1**		**2**		**1**		**4**		**4**	
61	electrode, ground	SD059		**1**		**1**		**1**		**1**		**1**		**1**	
62	tape, porous-hypoallergenic 2 in (Scanpore)	SG077		**24**		**48**		**24**		**48**		**48**		**48**	
63	paper, recording (per sheet)	SK059		**6**		**6**		**6**		**6**		**12**		**12**	
64	needle, blunt tip	SC034													
65	drape, non sterile, sheet 40in x 60 in	SB006		**1**		**1**		**1**		**1**		**1**		**1**	
66	acetone	SL001		**7**		**15**		**7**		**15**		**15**		**15**	
67	syringe 3ml	SC055													
68	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018		**0.17**				**0.17**				**0.34**		**0.34**	
69	measuring tape, paper	SK048		**1**		**1**		**1**		**1**		**1**		**1**	
70	swab-pad, alcohol	SJ053		**1**		**1**		**1**		**1**		**1**		**1**	
71	electrode conductive gel	SJ020		**1**		**1**		**1**		**1**		**2**		**2**	
72	Emory board	SK021		**1**		**1**		**1**		**1**		**1**		**1**	
73															
74	**EQUIPMENT**	**CODE**													
75	EMG-NCV-EP system, 8 channel	EQ024		**86**		**84.5**		**86**		**84.5**		**153**		**150**	
76	Table, Exam	EF023		**86**		**84.5**		**86**		**84.5**		**153**		**150**	
77	air compressor, safety	EQ047													
78	magnetic stimulator system (BiStim)	EQ180		**86**		**84.5**		**86**		**84.5**		**153**		**150**	
79	magnetic stimulator hand coil (70-90mm)	EQ178		**86**		**84.5**		**86**		**84.5**		**153**		**150**	
80	magnetic stimulator leg coil (110mm)	EQ179						**86**		**84.5**		**153**		**150**	
81	printer, laser, paper	ED032		**10**		**10**		**10**		**10**		**10**		**10**	
82															

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2011

Molecular Pathology-Tier 1

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010 and February 2011, the Panel accepted 92 Tier 1 codes, which are a list of gene-specific and genomic analysis CPT codes for high-volume molecular pathology services. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services. In April 2011, the specialty presented information on 18 Tier I codes, with the intent to provide data on additional 52 services in September 2011. At this time, the specialty indicated that physician interpretation is not typically required for the remaining 22 Tier I codes.

81206 ***BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative***
A survey of 62 pathologists indicated that the median time for 81206 was 15 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the work is similar to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37). **The RUC recommends a work RVU of 0.37 for CPT code 81206**.

81207 ***BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative***
A survey of 30 pathologists indicated that the median time for 81207 was 11 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the work is slightly more work and reflects higher intensity than 88302 Level II – *Surgical pathology, gross and microscopic examination* (time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81207.**

81208 ***BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative***
A survey of 16 pathologists indicated that the median time for 81208 was 18 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.46. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.46 accurately values this service relative to 81206 and 81207. In addition, 81208 requires slightly more physician work and time to perform compared to 88141 *Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician* (total time = 16 minutes, work = 0.42). **The RUC recommends a work RVU of 0.46 for CPT code 81208.**

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81220 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)***
A survey of 32 pathologists indicated that the median time for 81220 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that 81220 requires slightly more work to perform and is more intense than 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81220**.

81221 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **known familial variants**
A survey of 13 pathologists indicated that the median time for 81221 was 20 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.40. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.40 appropriately values this service relative to 81220 and 81222. In addition, 81221 requires less work and intensity to perform compared to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report (*total time = 20 minutes, work = 0.52). **The RUC recommends a work RVU of 0.40 for CPT code 81221.**

81222 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **duplication/deletion variants**
A survey of 6 pathologists indicated that the median time for 81222 was 13 minutes and reflects a median work RVU of 0.22. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81222 to 88304 *Level III Surgical pathology, gross and microscopic examination* (total time = 15 minutes, work = 0.22) and determined the physician work required to perform these services are equal. The RUC recommends the physician work for 81222 be crosswalked to 88304. In addition the RUC agreed that a work RVU of 0.22 places this service in the proper rank order relative to 81220 and 81221. **The RUC recommends a work RVU of 0.22 for CPT code 81222.**

81223 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **full gene sequence**
A survey of 9 pathologists indicated that the median time for 81223 was 20 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.40 is appropriate as 81223 requires the same physician work to perform as 81221. In addition, 81223 requires less physician work and intensity to perform compared to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52), therefore places the surveyed service in the proper rank order. **The RUC recommends a work RVU of 0.40 for CPT code 81223.**

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81224 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **intron 8 poly-T analysis (eg, male infertility)**
A survey of 14 pathologists indicated that the median time for 81224 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC agreed with the specialty that 81224 requires slightly more physician work to perform and is more intense compared to 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81224**.

81240 ***F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant***
A survey of 42 pathologists indicated that the median time for 81240 was 7 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work required to perform 81240 is equivalent to 88302 Level II *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81240.**

81241 ***F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant***
A survey of 41 pathologists indicated that the median time for 81241 was 8 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work required to perform 81241 is equivalent to 88302 Level II *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81241.**

81243 ***FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles***
A survey of 13 pathologists indicated that the median time for 81243 was 15 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.37. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 900 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81243 to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work = 0.37) and determined 81243 requires the same physician work to perform, which is supported by the survey 25th percentile work RVU of 0.37. **The RUC recommends a work RVU of 0.37 for CPT code 81243.**

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81244 ***FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)***
A survey of 11 pathologists indicated that the median time for 81244 was 20 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.51. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 100 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that work RVU of 0.51 appropriately values this service relative to the work and intensity of 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52). **The RUC recommends a work RVU of 0.51 for CPT code 81244.**

81256 ***HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)***
A survey of 18 pathologists indicated that the median time for 81256 was 7 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work is equivalent to 88302 *Level II Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and therefore should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81256**.

81270 ***JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant***
A survey of 46 pathologists indicated that the median time for 81270 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that 81270 requires slightly more physician work and is more intense to perform compared to 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81270.**

81275 ***KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis; variants in codons 12 and 13***
A survey of 43 pathologists indicated that the median time for 81275 was 20 minutes and reflects a 25th percentile work RVU of 0.50. The RUC agreed that survey 25th percentile work RVU of 0.50 appropriately values this service relative to the work and intensity required to perform 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52). **The RUC recommends a work RVU of 0.50 for CPT code 81275.**

81291 ***MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)***
A survey of 16 pathologists indicated that the median time for 81291 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 5,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC agreed with the specialty that 81291 requires slightly more physician work to perform than 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81291.**

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81315 ***PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative***
A survey of 27 pathologists indicated that the median time for 81243 was 15 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81315 to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work = 0.37) and determined that the surveyed code requires the same physician work to perform and therefore should be crosswalked. **The RUC recommends a work RVU of 0.37 for CPT code 81315.**

81316 ***PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative***
A survey of 15 pathologists indicated that the median time for 81316 was 12 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81316 to 88304 *Level III Surgical pathology, gross and microscopic examination* (total time = 15 minutes, work = 0.22) and determined that the surveyed code requires the same physician work to perform and therefore should be crosswalked. **The RUC recommends a work RVU of 0.22 for 81316.**

Practice Expense
The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However, these assumptions should be re-examined when greater experience is available for these services.

Work Neutrality
Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology
The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Pathology and Laboratory **Molecular Pathology**				
Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (eg, constitutional disorders) or somatic (eg, neoplasia) conditions, or to test for histocompatibility antigens (eg, HLA). Code selection is typically based on the specific gene(s) that is being analyzed. Genes are described using Human Genome Organization (HUGO) approved gene names and are italicized in the code descriptors. When the gene name is represented by an abbreviation, the abbreviation is listed first, followed by the full gene name italicized in parentheses (eg, "F5 *[coagulation Factor V]*"), except for the HLA series of codes. Proteins or diseases commonly associated with the genes are listed as examples in the code descriptors. The examples do not represent all conditions in which testing of the gene may be indicated. Codes that describe tests to assess for the presence of gene variants (see definitions) use common gene variant names. Typically, all of the listed variants would be tested. However, these lists are not exclusive. If other variants are also tested in the analysis, they would be included in the procedure and not reported separately. Full gene sequencing should not be reported using codes that assess for the presence of gene variants unless specifically stated in the code descriptor. The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection). Any procedures required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately. The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection). Any procedures required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately. The results of the procedure may require interpretation by a. When only the interpretation and report are performed, modifier 26 may be appended to the specific molecular pathology code. All analyses are qualitative unless otherwise noted. For microbial identification, see 87149-87153 and 87470-87801, and 87900-87904. For in situ hybridization analyses, see 88271-88275 and 88365-88368. Molecular pathology procedures that are not specified in 81200-81350 should be reported using the appropriate methodology codes in the 83890-83914 and 88384-88386 series.				

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81200		ASPA (aspartoacylase) (eg, Canavan disease) gene analysis; common variants (eg, E285A, Y231X)	XXX	Not Typically Performed by Physicians at this Time
●81205		BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis; common variants (eg, R183P, G278S, E422X)	XXX	Not Typically Performed by Physicians at this Time
●81206	M1	BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	XXX	0.37
●81207	M2	minor breakpoint, qualitative or quantitative	XXX	0.15
●81208	M3	other breakpoint, qualitative or quantitative	XXX	0.46
●81209		BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis; (eg, 2281del6ins7)	XXX	Not Typically Performed by Physicians at this Time
●81210	Z1	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	XXX	RUC Review September 2011
●81211		BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	XXX	Not Typically Performed by Physicians at this Time
●81212		185delAG, 5385insC, 6174delT variants	XXX	Not Typically Performed by Physicians at this Time

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81213		uncommon duplication/deletion variants	XXX	Not Typically Performed by Physicians at this Time
●81214		BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb) (When performing BRCA1 full sequence analysis with BRCA2 full sequence analysis use 81211)	XXX	Not Typically Performed by Physicians at this Time
●81215		known familial variant	XXX	Not Typically Performed by Physicians at this Time
●81216		BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis (When performing BRCA2 full sequence analysis with BRCA1 full sequence analysis use 81211)	XXX	Not Typically Performed by Physicians at this Time
●81217		known familial variant	XXX	Not Typically Performed by Physicians at this Time
●81220	M4	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	XXX	0.15
●81221	M5	known familial variants	XXX	0.40
●81222	M6	duplication/deletion variants	XXX	0.22
●81223	M7	full gene sequence	XXX	0.40

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81224	M8	intron 8 poly-T analysis (eg, male infertility)	XXX	0.15
●81225	Z2	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	XXX	RUC Review September 2011
●81226	Z3	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	XXX	RUC Review September 2011
●81227	Z4	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	XXX	RUC Review September 2011
●81228		Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	XXX	Not Typically Performed by Physicians at this Time
●81229		interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (Do not report 81228 in conjunction with 81229)	XXX	Not Typically Performed by Physicians at this Time
●81240	M9	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant	XXX	0.13
●81241	M10	F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant	XXX	0.13
●81242		FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis; common variant (eg, IVS4+4A>T)	XXX	Not Typically Performed by Physicians at this Time

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81243	M11	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles (For evaluation to detect and characterize abnormal alleles, see 81243, 81244) (For evaluation to detect and characterize abnormal alleles using a single assay [eg, PCR], use 81243)	XXX	0.37
●81244	M12	characterization of alleles (eg, expanded size and methylation status)	XXX	0.51
●81245	Z6	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	XXX	RUC Review September 2011
●81250		G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis; common variants (eg, R83C, Q347X)	XXX	Not Typically Performed by Physicians at this Time
●81251		GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis; common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	XXX	Not Typically Performed by Physicians at this Time
●81255		HEXA (hexosaminidase A (alpha polypeptide) (eg, Tay-Sachs disease) gene analysis; common variants (eg, 1278insTATC, 1421+1G>C, G269S)	XXX	Not Typically Performed by Physicians at this Time
●81256	M13	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)	XXX	0.13
●81257	Z7	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean,	XXX	RUC Review September 2011

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		alpha3.7, alpha4.2, alpha20.5, and Constant Spring)		
●81260		IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis; common variants (eg, 2507+6T>C, R696P)	XXX	Not Typically Performed by Physicians at this Time
● 81261	Z8	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	XXX	RUC Review September 2011
●81262	Z9	direct probe methodology (eg, Southern blot)	XXX	RUC Review September 2011
●81263	Z10	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	XXX	RUC Review September 2011
●81264	Z11	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s) (For immunoglobulin lambda gene [IGL@] rearrangement or immunoglobulin kappa deleting element, [IGKDEL] analysis, report the appropriate methodology code[s] in the 83890-83914 series)	XXX	RUC Review September 2011
●81265	Z12	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	XXX	RUC Review September 2011

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+●81266	Z13	each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure) (Use 81266 in conjunction with 81265)	ZZZ	RUC Review September 2011
●81267	Z14	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection	XXX	RUC Review September 2011
●81268	Z15	with cell selection (eg, CD3, CD33), each cell type (If baseline STR analysis of recipient [using buccal swab or other germline tissue sample] and donor are performed after hematopoietic stem cell transplantation, report 81265-81266 in conjunction with 81267-81268 for chimerism testing)	XXX	RUC Review September 2011
●81270	M14	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant	XXX	0.15
●81275	M15	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis; variants in codons 12 and 13	XXX	0.50
●81280		Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); full sequence analysis	XXX	Not Typically Performed by Physicians at this Time
●81281		known familial sequence variant	XXX	Not Typically Performed by Physicians at this Time

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81282		duplication/deletion variants	XXX	Not Typically Performed by Physicians at this Time
●81290		MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis; common variants (eg, IVS3-2A>G, del6.4kb)	XXX	Not Typically Performed by Physicians at this Time
●81291	M16	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)	XXX	0.15
●81292	Z16	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81293	Z17	known familial variants	XXX	RUC Review September 2011
●81294	Z18	duplication/deletion variants	XXX	RUC Review September 2011
●81295	Z19	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81296	Z20	known familial variants	XXX	RUC Review September 2011
●81297	Z21	duplication/deletion variants	XXX	RUC Review September 2011
●81298	Z22	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81299	Z23	known familial variants	XXX	RUC Review September 2011

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81300	Z24	duplication/deletion variants	XXX	RUC Review September 2011
●81301	Z25	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	XXX	RUC Review September 2011
●81302	Z26	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
● 81303	Z27	known familial variant	XXX	RUC Review September 2011
●81304	Z28	duplication/deletion variants	XXX	RUC Review September 2011
●81310	Z29	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	XXX	RUC Review September 2011
●81315	M17	PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	XXX	0.37
●81316	M18	single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative (For intron 3 and intron 6 [including exon 6 if performed] analysis, use 81315) (If both intron 6 and exon 6 are analyzed, without intron 3, use one unit of 81316)	XXX	0.22

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81317	Z30	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81318	Z31	known familial variants	XXX	RUC Review September 2011
●81319	Z32	duplication/deletion variants	XXX	RUC Review September 2011
●81330		SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis; common variants (eg, R496L, L302P, fsP330)	XXX	Not Typically Performed by Physicians at this Time
●81331	Z33	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	XXX	RUC Review September 2011
●81332	Z34	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	XXX	RUC Review September 2011
●81340	Z35	TCB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	XXX	RUC Review September 2011
●81341	Z36	using direct probe methodology (eg, Southern blot)	XXX	RUC Review September 2011
●81342	Z37	TCG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	XXX	RUC Review September 2011

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For T cell antigen alpha [TCA@] gene rearrangement analysis, report the appropriate methodology code(s) in the 83890-83914 series) (For T cell antigen delta [TCD@] gene rearrangement analysis, report 81341)		
●81350	Z38	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	XXX	RUC Review September 2011
●81355	Z5	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	XXX	RUC Review September 2011
Human Leukocyte Antigen (HLA) typing is performed to assess compatibility of recipients and potential donors as a part of solid organ and hematopoietic stem cell pretransplant testing. HLA testing is also performed to identify HLA alleles and allele groups (antigen equivalents) associated with specific diseases and individualized responses to drug therapy (eg, HLA-B*27 and ankylosing spondylitis and HLA-B*57:01 and abacavir hypersensitivity) as well as other clinical uses. One or more HLA genes may be tested in specific clinical situations (eg, HLA-DQB1 for narcolepsy and HLA-A, -B, -C, -DRB1 and -DQB1 for kidney transplantation). Each HLA gene typically has multiple variant alleles or allele groups that can be identified by typing. For HLA result reporting, a low resolution HLA type is denoted by a two digit HLA name (eg, A*02) and high resolution typing is denoted by a greater number of digits (eg, A*02:02, *03:01:01:01, and C*03:04P). If additional testing is required to resolve ambiguous allele combinations for high resolution typing, it is included in the HLA typing code. The gene names have been italicized similar to the other molecular pathology codes. (For HLA antigen typing by non-molecular pathology techniques, see 86812-86822)				
●81370	Z39	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	XXX	RUC Review September 2011
●81371	Z40	HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	XXX	RUC Review September 2011

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●81372	Z41	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C) (When performing both Class I and II low resolution HLA typing for HLA-A,-B,-C, -DRB1/3/4/5, and -DQB1, use 81370)	XXX	RUC Review September 2011
●81373	Z42	one locus (eg, HLA-A, -B, or -C), each (When performing a complete Class I [HLA-A,-B, and -C] low resolution HLA typing, use 81372) (When the presence or absence of a single antigen equivalent is reported using low resolution testing, use 81374)	XXX	RUC Review September 2011
●81374	Z43	one antigen equivalent (eg, B*27), each (When testing for presence or absence of more than 2 antigen equivalents at a locus, use HLXX4 for each locus tested)	XXX	RUC Review September 2011
●81375	Z44	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1 (When performing both Class I and II low resolution HLA typing for HLA-A,-B,-C, -DRB1/3/4/5, and –DQB1, use 81370)	XXX	RUC Review September 2011
●81376	Z45	one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each (When low resolution typing is performed for HLA-DRB1/3/4/5 and -DQB1, use HLXX6) (For low resolution typing, HLA-DRB1/3/4/5 should be	XXX	RUC Review September 2011

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		treated as a single locus)		
●81377	Z46	one antigen equivalent, each (When testing for presence or absence of more than 2 antigen equivalents at a locus, use 81379 for each locus)	XXX	RUC Review September 2011
●81378	Z47	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	XXX	RUC Review September 2011
●81379	Z48	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	XXX	RUC Review September 2011
●81380	Z49	one locus (eg, HLA-A, -B, or -C), each (When a complete Class I high resolution typing for HLA-A,-B, and -C is performed, use 81379) (When the presence or absence of a single allele or allele group is reported using high resolution testing, use 81381)	XXX	RUC Review September 2011
●81381	Z50	one allele or allele group (eg, B*57:01P), each (When testing for the presence or absence of more than 2 alleles or allele groups at a locus, use 81380 for each locus)	XXX	RUC Review September 2011
●81382	Z51	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3,-DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each (When only the presence or absence of a single allele or allele group is reported using high resolution testing, use 81383)	XXX	RUC Review September 2011
●81383	Z52	one allele or allele group (eg, HLA-DQB1*06:02P),	XXX	RUC Review September 2011

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		each (When testing for the presence or absence of more than 2 alleles or allele groups at a locus, use 81382 for each locus)		
83912		Molecular diagnostics; interpretation and report	XXX	0.37 (No Change)
E 86822		HLA typing; lymphocyte culture, primed (PLC) (For HLA typing by molecular pathology techniques, see 81370-8138383890-83914 ~~with appropriate genetic testing modifiers 4A-4G~~)	XXX	Paid on Clinical Lab Fee Schedule

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February 25, 2011

Barbara Levy, MD
Chair, RVS Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60654

Re: New Molecular Pathology CPT Codes

Dear Dr. Levy:

The College of American Pathologists (CAP) supports physician fee schedule placement of the 28 Tier 1 molecular pathology codes approved at the October 2010 CPT Meeting, and the 9 Tier 2 codes approved at the February 2011 CPT meeting, as they all have a professional interpretive component. However, the Centers for Medicare and Medicaid Services (CMS) and the AMA/Specialty Society Relative Value Scale Update Committee (RUC) have specifically requested that the CAP bring forward at this time only proposed values for April 2011 RUC review that typically include physician interpretation.

The 28 Tier 1 codes and 9 Tier 2 codes identified in CAP's plan for review at the April RUC have been reviewed by a subgroup of CAP molecular pathologists together with our RBRVS workgroup. Of these 37 codes, 10 were determined to have their interpretation typically performed by a PhD at this time. These services are currently not typically performed in typical molecular pathology laboratories, but rather in subspecialty laboratories.

Therefore, in response to CMS' and the RUC's direct request, only the following codes will be presented at the April RUC meeting, because the interpretation of these codes is typically performed by a physician. In addition, the CAP reviewed the recently approved CPT codes from the February CPT meeting and determined which codes are typically interpreted by physicians.

As you know, at the February meeting, the RUC approved a plan outlining how CAP proposes to move forward in developing recommended values and direct practice expense inputs for the molecular pathology codes approved by the CPT Editorial Panel at its October 2010 and February 2011 meetings. This plan is to survey for April 2011 the 28 Tier 1 molecular codes and the 9 Tier 2 codes approved by CPT in February. Because of the RUC directive, 27 codes will be surveyed for the April RUC meeting. The remaining molecular codes approved at the February CPT meeting and identified as typically including physician work will be surveyed for the September 2011 RUC meeting.

Below please find the codes to be surveyed for the April 2011 RUC meeting, codes to be surveyed for the September 2011 RUC meeting, and codes not scheduled to be surveyed at this time.

Codes to be Surveyed for April 2011 RUC Meeting

Tier 1

●BXXX2	*BCR/ABL1 (t[9;22])* (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
●BXXX3	minor breakpoint, qualitative or quantitative
●BXXX4	other breakpoint, qualitative or quantitative
●CXXX1	*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)
●CXXX2	known familial variants
●CXXX3	duplication/deletion variants
●CXXX4	full gene sequence
●CXXX5	intron 8 poly-T analysis (eg, male infertility)
●FXXX1	*F2 (prothrombin, coagulation factor II)* (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant
●FXXX2	*F5 (coagulation Factor V)* (eg, hereditary hypercoagulability) gene analysis; Leiden variant
●FXXX4	*FMR1 (Fragile X mental retardation 1)* (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
●FXXX5	characterization of alleles (eg, expanded size and methylation status)
●HXXX2	*HFE (hemochromatosis)* (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)
●JXXX1	*JAK2 (Janus kinase 2)* (eg, myeloproliferative disorder) gene analysis; V617F variant
●KXXX1	*KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene)* (eg, carcinoma) gene analysis; variants in codons 12 and 13
●MXXX2	*MTHFR (5,10-methylenetetrahydrofolate reductase)* (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)
●PXXX1	*PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1)* (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative
●PXXX2	single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative

Tier 2

●L2XX1	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)
●L2XX2	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

●L2XX3 Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)

●L2XX4 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

●L2XX5 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

●L2XX6 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

●L2XX7 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

●L2XX8 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

●L2XX9 Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

Codes to be Surveyed for September 2011 RUC Meeting

Tier 1

●BXXX6 *BRAF (v-raf murine sarcoma viral oncogene homolog B1)* (eg, colon cancer), gene analysis, V600E variant

●CXXX6 *CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)

●CXXX7 *CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)

●CXXX8 *CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)

●CXXX9 *VKORC1 (vitamin K epoxide reductase complex, subunit 1)* (eg, warfarin metabolism), gene analysis, common variants (eg, 1639/3673)

●FXXX6 *FLT3 (fms-related tyrosine kinase 3)* (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)

●HXXX3 *HBA1/HBA2 (alpha globin 1 and alpha globin 2)* (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)

● IXXX2 *IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)

●IXXX3 direct probe methodology (eg, Southern blot)

●IXXX4 *IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis

●IXXX5 *IGK@ (Immunoglobulin kappa light chain locus)* (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)

●IXXX6 Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)

+●IXXX7 each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)

●IXXX8 Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection

●IXXX9 with cell selection (eg, CD3, CD33), each cell type

●MXXX3 *MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

●MXXX4 known familial variants

●MXXX5 duplication/deletion variants

●MXXX6 *MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

●MXXX7 known familial variants

●MXXX8 duplication/deletion variants

●MXXX9 *MSH6 (mutS homolog 6 [E. coli])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

●MXX10 known familial variants

●MXX11 duplication/deletion variants

●MXX12 Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed

●MXX13 *MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; full sequence analysis

●MXX14 known familial variant

●MXX15 duplication/deletion variants

●NXXX3 *NPM1 (nucleophosmin)* (eg, acute myeloid leukemia) gene analysis, exon 12 variants

●PXXX3 *PMS2 (postmeiotic segregation increased 2 [S. cerevisiae])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

●PXXX4 known familial variants

●PXXX5 duplication/deletion variants

●SXXX2 *SNRPN/UBE3A* (*small nuclear ribonucleoprotein polypeptide* N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis

●SXXX3 *SERPINA1* (*serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1)* (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)

●TXXX1 *TCB@ (T cell antigen receptor, beta)* (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)

●TXXX2 using direct probe methodology (eg, Southern blot)

●TXXX3 *TCG@ (T cell antigen receptor, gamma)* (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)

●UXXX1 *UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1)* (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)

●HLXX1 HLA Class I and II typing, low resolution (eg, antigen equivalents); *HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1*

●HLXX2 *HLA-A, -B, and -DRB1/3/4/5* (eg, verification typing)

●HLXX3 HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, *HLA-A*, *-B*, and *-C*)

●HLXX4 one locus (eg, *HLA-A*, *-B*, or *-C*), each

●HLXX5 one antigen equivalent (eg, *B*27*), each

●HLXX6 HLA Class II typing, low resolution (eg, antigen equivalents); HLA-*DRB1/3/4/5* and *-DQB1*

- ●HLXX7 one locus (eg, *HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1*, or *-DPA1*), each
- ●HLXX8 one antigen equivalent, each
- ●HLXX9 HLA Class I and II typing, high resolution (ie, alleles or allele groups), *HLA-A, -B, -C,* and *-DRB1*
- ●HLX10 HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, *HLA-A, -B,* and -C)
- ●HLX11 one locus (eg, *HLA-A, -B,* or -C), each
- ●HLX12 one allele or allele group (eg, *B*57:01P*), each
- ●HLX13 HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, *HLA-DRB1, -DRB3,-DRB4, -DRB5, -DQB1, -DQA1, -DPB1,* or *-DPA1*), each
- ●HLX14 one allele or allele group (eg, *HLA-DQB1*06:02P*), each

Codes not being surveyed at this time per RUC/CMS directive to CAP

(October 2010 CPT Meeting)

●AXXX1 *ASPA* (*aspartoacylase*) (eg, Canavan disease) gene analysis; common variants (eg, E285A, Y231X)

●BXXX1 *BCKDHB* (*branched-chain keto acid dehydrogenase E1, beta polypeptide*) (eg, Maple syrup urine disease) gene analysis; common variants (eg, R183P, G278S, E422X)

●BXXX5 *BLM (Bloom syndrome, RecQ helicase-like)* (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant

●FXXX3 *FANCC (Fanconi anemia, complementation group C) (*eg, Fanconi anemia, type C) gene analysis; common variant (eg, IVS4+4A>T)

●GXXX1 *G6PC (glucose-6-phosphatase, catalytic subunit)* (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis; common variants (eg, R83C, Q347X)

●GXXX2 *GBA (glucosidase, beta, acid)* (eg, Gaucher disease) gene analysis; common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)

●HXXX1 *HEXA (hexosaminidase A (alpha polypeptide)* (eg, Tay-Sachs disease) gene analysis; common variants (eg, 1278insTATC, 1421+1G>C, G269S)

●IXXX1 *IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein)* (eg, familial dysautonomia) gene analysis; common variants (eg, 2507+6T>C, R696P)

●MXXX1 *MCOLN1* (*mucolipin 1*) (eg, Mucolipidosis, type IV) gene analysis; common variants (eg, IVS3-2A>G, del6.4kb)

●SXXX1 *SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal)* (eg, Niemann-Pick disease, Type A) gene analysis; common variants (eg, R496L, L302P, fsP330)

(February 2011 CPT Meeting)

●BXXX7 *BRCA1, BRCA2 (breast cancer 1 and 2)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in *BRCA1* (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)

●BXXX8 185delAG, 5385insC, 6174delT variants

●BXXX9 uncommon duplication/deletion variants

●BXX10 *BRCA1 (breast cancer 1)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)

●BXXX11 known familial variant

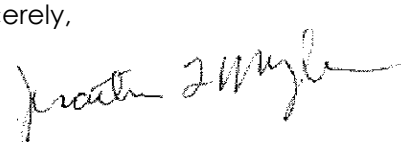
●BXX12 *BRCA2* (*breast cancer 2*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis

- ●BXX13 known familial variant
- ●CXX10 Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
- ●CXX11 interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
- ●LXXX1 Long QT syndrome gene analyses (eg, *KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2)*; full sequence analysis
- ●LXXX2 known familial sequence variant
- ●LXXX3 duplication/deletion variants

If you have any questions or concerns, please contact Kim Chisolm, Assistant Director of Economic Affairs at (202) 354-7118 or kchisol@cap.org.

Thank you for providing us the opportunity to present this plan.

Sincerely,



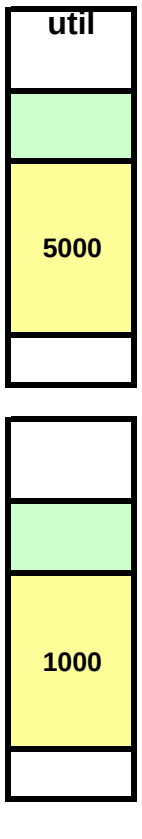
Jonathan L. Myles, MD, FCAP
CAP RUC Advisor
College of American Pathologists

jlm/kmc
Sent via email

cc: Kenneth Simon, MD, MBA, CMS
Edith Hambrick, MD, JD, CMS
Susan Spires, MD, RUC Member
J. Allan Tucker, MD, RUC Alternate Member
Mark Synovec, MD, CPT Member
Sherry Smith, AMA RUC Staff
Roseanne Fischoff, AMA RUC Staff
Kim Chisolm, CAP RUC Staff
Ayanna Wooding, CAP CPT Staff

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time		Total-TIME				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX
REF	86320	Immunoelectrophoresis; serum	32	0.0220			0.37			17				17		
SVY	81315	PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	27	0.035	0.20	0.51	0.52	0.61	0.95			3	8	15	23	30
REC				0.025			0.37							15		

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time		Total-TIME				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX
REF	88304	Level III - Surgical pathology, gross and microscopic examination					0.22			15				15		
SVY	81316	PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	15	0.038	0.20	0.37	0.45	0.57	0.80			5	8	12	18	30
REC				0.018			0.22							12		


util
5000
1000

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81206 Tracking Number M1 Original Specialty Recommended RVU: **0.39**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old man diagnosed with chronic myelogenous leukemia (CML) on maintenance therapy with imatinib mesylate sees his oncologist for a routine follow-up visit. Molecular studies at diagnosis confirmed the presence of a Philadelphia chromosome with the major breakpoint translocation joining the BCR and ABL1 genes. The patient feels well and has no complaints, and a hemogram in the office demonstrates normal white cell, red cell, and platelet counts. A sample of anticoagulated peripheral blood is submitted to the laboratory for quantitative assessment of BCR/ABL1 major breakpoint transcript level.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality total cellular RNA is isolated and stored under RNase-free conditions. Working in duplicate from this point, reverse transcriptase is used to convert RNA to cDNA followed by quantitative real-time PCR amplification using primers for both the BCR/ABL1 major breakpoint translocation as well as a 'housekeeping gene' necessary to normalize BCR/ABL1 expression levels. Thephysician reviews the real-time PCR tracings to determine the status of the of BCR/ABL1 major breakpoint transcripts, that the assay is performing at acceptable sensitivity, and whether RNA degradation or inhibitors of PCR are present. The physician reviews duplicate values as well as the ratio of BCR/ABL1 to housekeeping gene expression for patient and control samples. Values are converted to an international reporting standard using a previously-determined correction factor for the laboratory's assay. The physician composes a report that describes the transcript status and copy number, and compares these results with the patient's previous results. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP					
Specialty(s):	College of American Pathologists					
CPT Code:	81206					
Sample Size:	450	**Resp N:**	62	**Response:** 13.7 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	50.00	**100.00**	200.00	700.00
Survey RVW:	0.10	0.41	**0.52**	0.74	1.40
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81206	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.31	**RUC Time**	1,231,072

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 41.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 81206**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.23	3.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.54
Urgency of medical decision making	3.62	3.54
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.92	4.15
Physical effort required	3.00	3.12
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.62	3.69
Outcome depends on the skill and judgment of physician	3.62	3.69
Estimated risk of malpractice suit with poor outcome	3.08	3.19

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.69	3.86
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.39.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
35,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81207 Tracking Number M2 Original Specialty Recommended RVU: **0.29**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old-woman diagnosed with acute lymphocytic leukemia (ALL) treated with imatinib mesylate and hyper-CVAD therapy sees her oncologist for a routine follow-up visit. Molecular studies at diagnosis confirmed the presence of a Philadelphia chromosome with the minor breakpoint translocation joining the BCR and ABL1 genes. The patient feels well and has no complaints, and a hemogram in the office demonstrates normal white cell, red cell, and platelet counts. A sample of anticoagulated bone marrow is submitted to the laboratory for quantitative assessment of BCR/ABL1 minor breakpoint transcript level.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality total cellular RNA is isolated and stored under RNase-free conditions. Working in duplicate from this point, reverse transcriptase is used to convert RNA to cDNA followed by quantitative real-time PCR amplification using primers for both the BCR/ABL1 minor breakpoint translocation as well as a 'housekeeping gene' necessary to normalize BCR/ABL1 expression levels. The physician reviews the real-time PCR tracings to determine the status of BCR/ABL1 minor breakpoint transcripts, that the assay is performing at acceptable sensitivity and whether RNA degradation or inhibitors of PCR are present. The physician reviews duplicate values as well as the ratio of BCR/ABL1 to housekeeping gene expression for patient and control samples. The physician composes a report that describes the transcript status and whether disease level appears to be stable, increasing or decreasing. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81207		
Sample Size:	450	**Resp N:** 30	**Response:** 6.6 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	20.00	**50.00**	100.00	300.00
Survey RVW:	0.25	0.40	**0.50**	0.55	1.39
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**11.00**	20.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81207	**Recommended Physician Work RVU: 0.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**11.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 56.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81207**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	11.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**11.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.29	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.47
Urgency of medical decision making	3.53	3.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	2.94	2.88
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.65	3.47
Outcome depends on the skill and judgment of physician	3.76	3.76
Estimated risk of malpractice suit with poor outcome	2.88	3.06

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.65	3.88
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.29.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81208 Tracking Number M3 Original Specialty Recommended RVU: **0.46**
Presented Recommended RVU: **0.46**
Global Period: XXX RUC Recommended RVU: **0.46**

CPT Descriptor: BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis ;other breakpoint, qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old woman visits her primary care physician complaining of abdominal discomfort. Splenomegaly is identified on physical examination. A hemogram demonstrates leukocytosis with a left shift along with modest anemia and thrombocytopenia. Cytogenetic analysis demonstrates a classic Philadelphia chromosome, but studies for BCR/ABL1 major and minor breakpoints are negative. A sample of anticoagulated peripheral blood is submitted to the laboratory for assessment of the uncommon BCR/ABL1 'micro'(u) translocation breakpoint.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality total cellular RNA is isolated and stored under RNase-free conditions. Working in duplicate from this point, reverse transcriptase is used to convert RNA to cDNA followed by qualitative real-time PCR amplification using primers specific for the BCR/ABL1 micro(u) breakpoint translocation as well as a 'housekeeping gene. Thephysician reviews the real-time PCR tracings to the status of a BCR/ABL1 micro breakpoint translocation and whether RNA degradation or inhibitors of PCR are present. The physician composes a report which specifies the status of the translocation. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP					
Specialty(s):	College of American Pathologists					
CPT Code:	81208					
Sample Size:	450	**Resp N:**	16	**Response:** 3.5 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	10.00	**25.00**	52.50	400.00
Survey RVW:	0.45	0.46	**0.50**	0.52	1.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**18.00**	30.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81208	**Recommended Physician Work RVU: 0.46**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,175,839

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,580,775

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 68.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 81208**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	18.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**18.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.55
Urgency of medical decision making	3.64	3.64
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.91	3.91
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.45	3.36
Outcome depends on the skill and judgment of physician	3.82	3.82
Estimated risk of malpractice suit with poor outcome	3.64	3.64

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.73	3.55
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.46.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81220 Tracking Number M4 Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26-year-old Caucasian woman, approximately 8 weeks pregnant and otherwise in good health, visits her obstetrician for a first prenatal visit. After discussing advantages and limitations of prenatal cystic fibrosis carrier screening with her obstetrician, an anticoagulated peripheral blood sample is sent to the laboratory to be tested for common mutations and variants associated with cystic fibrosis.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated and subjected to multiplex PCR. Following exonuclease I and shrimp alkaline phosphatase treatment, a second reaction using allele specific primer extension (ASPE) amplifies either the normal or mutant allele sequences. Extension products are hybridized to color-coded microspherical beads specific for normal and mutant alleles. The fluorescent signal ratio of mutant to normal alleles is calculated, and the physician examines the allelic ratios to determine the mutation and zygosity status. The physician composes a report which specifies the patient's mutation status and residual risk based on ethnic background. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81220				
Sample Size:	450	**Resp N:**	32	**Response:** 7.1 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	10.00	**250.00**	425.00	800.00
Survey RVW:	0.15	0.38	**0.50**	0.66	1.30
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	8.00	**10.00**	20.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81220	**Recommended Physician Work RVU: 0.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,334,268

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 37.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81220**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**10.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.75	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.83
Urgency of medical decision making	3.08	2.95
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.25	3.00
Physical effort required	2.08	2.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.42	3.00
Outcome depends on the skill and judgment of physician	3.25	3.17
Estimated risk of malpractice suit with poor outcome	4.33	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.08	3.00
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.22.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81221 Tracking Number M5 Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 1-year-old Caucasian boy whose 6-year-old brother was previously diagnosed with cystic fibrosis is brought by his mother to the pediatrician for genetic testing. The brother was previously demonstrated to be a compound heterozygote carrying one copy each of the common CFTR DeltaF508 mutation as well as a rare variant not included in assays which test for common variants of CFTR but known to cause cystic fibrosis. An anticoagulated peripheral blood sample is sent to the laboratory for testing of these known mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality DNA is isolated from whole blood and subjected to PCR amplification for the respective CFTR gene exons which contain the known familial mutations. Following exonuclease I and shrimp alkaline phosphatase treatment, each PCR product undergoes bidirectional Sanger dideoxynucleotide chain termination sequencing using appropriate forward and reverse primers. Sequencing products are analyzed on a capillary electrophoresis instrument and electropherograms printed for visual inspection and transferred to a software program to identify potential nucleotide sequence changes. The physician composes a report specifying the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81221		
Sample Size:	450	**Resp N:** 13	**Response:** 2.8 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	12.00	**20.00**	50.00	250.00
Survey RVW:	0.32	0.40	**0.50**	0.77	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	10.00	**20.00**	25.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81221	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	090	0.22	**RUC Time**	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 46.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 81221**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**20.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.67
Urgency of medical decision making	3.83	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.17	4.17
Physical effort required	3.17	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	3.83
Outcome depends on the skill and judgment of physician	4.33	4.33
Estimated risk of malpractice suit with poor outcome	4.83	4.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.83	3.83
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.40.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81222 Tracking Number M6 Original Specialty Recommended RVU: **0.28**
Presented Recommended RVU: **0.22**
Global Period: XXX RUC Recommended RVU: **0.22**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old Caucasian female previously diagnosed with cystic fibrosis based on convincing clinical criteria and two elevated sweat chloride results visits her pediatrician with her father to discuss potential additional genetic testing. Previous tests with a screening assay for common mutations and variants followed by CFTR full gene sequence analysis revealed only heterozygosity for the DeltaF508 mutation. An anticoagulated peripheral blood sample is forwarded to a reference laboratory for deletion/duplication analysis for an uncommon CFTR mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen high quality DNA is isolated from whole blood and subjected to multiplex ligation probe ligation analysis (MLPA) which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 27 exons of the CFTR gene to assess dosage of each exon. The physician examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the CFTR gene. The physician composes a report specifying the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81222		
Sample Size:	450	**Resp N:** 6	**Response:** 1.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	25.00	72.50	**250.00**	300.00	500.00
Survey RVW:	0.22	0.33	**0.40**	0.44	0.52
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**13.00**	19.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81222	**Recommended Physician Work RVU: 0.22**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**13.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81222**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	13.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**13.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
Urgency of medical decision making	3.00	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	2.33	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	4.00
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	4.67	4.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.67	3.33
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.28.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.tacking codes for the TC and 83912 for the PC.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81223 Tracking Number M7 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old Caucasian female with chronic rhino-sinusitis, idiopathic bronchiectasis and two sweat chloride measurements in the intermediate range (40-60 meq/L) is suspected by her pediatrician of having an atypical form of cystic fibrosis. A tube of anticoagulated peripheral blood is submitted to the laboratory for full CFTR gene sequence analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality DNA is isolated from whole blood and subjected to 29 individual PCR amplification reactions whose products encompass the entire coding sequence, exon-intron boundaries and portions of 5' and 3'-untranslated regions of the CFTR gene. Following exonuclease I and shrimp alkaline phosphatase treatment, each PCR product undergoes bidirectional Sanger dideoxynucleotide chain termination sequencing using appropriate forward and reverse primers. Sequencing products are analyzed on a capillary electrophoresis instrument and electropherograms printed for visual inspection and transferred to a software program to identify potential nucleotide sequence changes. The physician composes a report specifying the patient's mutation status to include information from a literature and database search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81223		
Sample Size:	450	**Resp N:** 9	**Response:** 2.0 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	10.00	**20.00**	50.00	500.00
Survey RVW:	0.52	0.52	**0.75**	0.77	1.18
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	15.00	**20.00**	30.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81223	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,580,775

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	115,072

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 55.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81223**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.20	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.20
Urgency of medical decision making	4.20	4.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	4.20
Physical effort required	3.20	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.40	4.40
Outcome depends on the skill and judgment of physician	4.40	4.60
Estimated risk of malpractice suit with poor outcome	4.40	4.40

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.60	4.40
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.52.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81224 Tracking Number M8 Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following recent consultation with his family physician regarding his wife's difficulty in conceiving a child, a 34-year-old Caucasian male is referred to an urologist for infertility workup. Further examination reveals bilateral absence of the vas deferens. The urologist recommends genetic analysis of the CFTR gene to look for common CFTR mutations and assess the intron 8 poly-T region frequently associated with male infertility. An anticoagulated peripheral blood sample is forwarded to the laboratory for testing.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated and subjected to multiplex PCR. Following exonuclease I and shrimp alkaline phosphatase treatment, a second reaction using allele specific primer extension (ASPE) amplifies either normal or mutant allele sequences including poly-T length variants. Extension products are hybridized to color-coded microspherical beads specific for normal and mutant alleles as well as poly-T length variants in intron 8. The fluorescent signal ratio of mutant, normal and poly-T alleles is calculated, and the physician examines the allelic ratios to determine the mutation, zygosity and specific poly-T allele status. The physician composes a report which specifies the patient's mutation and poly-T status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81224		
Sample Size:	450	**Resp N:** 14	**Response:** 3.1 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	6.25	**20.00**	55.75	500.00
Survey RVW:	0.32	0.40	**0.49**	0.79	0.94
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	8.00	**10.00**	15.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81224	**Recommended Physician Work RVU: 0.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,334,268

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 35.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 81224**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**10.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.80	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.80
Urgency of medical decision making	2.60	2.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.80	2.60
Physical effort required	2.20	2.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.60	2.60
Outcome depends on the skill and judgment of physician	2.80	2.80
Estimated risk of malpractice suit with poor outcome	3.40	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.80	2.60
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.22.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81240 Tracking Number M9 Original Specialty Recommended RVU: **0.15**
Presented Recommended RVU: **0.13**
Global Period: XXX RUC Recommended RVU: **0.13**

CPT Descriptor: F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with anxiety and kidney stones presented with two-week history of shortness of breath and pleuritic chest pain. Diagnostic workup revealed multiple bilateral pulmonary emboli. There was a vague history of other family members having "clotting problems." A sample of anticoagulated peripheral blood is submitted to the laboratory for F2 (Prothrombin, coagulation factor II) mutation testing for the 20210G>A variant.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic region containing the site of the F2 20210G>A mutation site is amplified by PCR and the amplicon is then subjected to melting curve analysis. The physician examines the melting curve plot of red fluorescent signal vs. temperature, as well as the plot of the negative first derivative of red fluorescent signal vs. temperature. Based on the analysis of these curves, and comparison to the results obtained with wild type and mutant controls, the physician determines the F2 20210G>A mutation and zygosity status. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81240				
Sample Size:	450	**Resp N:**	42	**Response:** 9.3 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	57.50	**150.00**	300.00	600.00
Survey RVW:	0.13	0.31	**0.37**	0.40	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**7.00**	10.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81240	**Recommended Physician Work RVU: 0.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95165	XXX	0.06	**RUC Time**	5,412,909

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73560	XXX	0.17	**RUC Time**	2,137,514

CPT Descriptor 2 Radiologic examination, knee; 1 or 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81240**	**Key Reference CPT Code:** 86320	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	7.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**7.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.52	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	3.00
Urgency of medical decision making	2.43	2.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.95	3.19
Physical effort required	2.10	2.10
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.90	3.10
Outcome depends on the skill and judgment of physician	2.81	3.24
Estimated risk of malpractice suit with poor outcome	2.86	2.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.67	3.00
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.15.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
22,000 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81241 Tracking Number M10 Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.13**
Global Period: XXX RUC Recommended RVU: **0.13**

CPT Descriptor: F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old woman developed a right femoral venous thrombosis following a 3-hour airplane flight and subsequently developed pulmonary emboli. She had been on oral contraception. There was a vague history of other family members having "clotting problems." A functional, clot-based screening test for resistance to activated protein C (i.e., activated protein C resistance assay, APCR) was positive. A sample of anticoagulated peripheral blood is submitted to the laboratory for F5 Leiden mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic region containing the site of the F5 Leiden mutation site is amplified by PCR, and the amplicon is then subjected to melting curve analysis. The physicians examines the melting curve plot of red fluorescent signal vs. temperature, as well as the plot of the negative first derivative of red fluorescent signal vs. temperature. Based on the analysis of these curves, and comparison to the results obtained with wild type and mutant controls, the physician determines the F5 Leiden mutation and zygosity status. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81241				
Sample Size:	450	**Resp N:**	41	**Response:** 9.1 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	50.00	**150.00**	300.00	750.00
Survey RVW:	0.13	0.30	**0.37**	0.40	0.76
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**8.00**	10.00	15.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81241	**Recommended Physician Work RVU: 0.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**8.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95165	XXX	0.06	**RUC Time**	5,412,909

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 53.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81241**	**Key Reference CPT Code:** 86320	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	8.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**8.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.59	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.64	2.91
Urgency of medical decision making	2.55	2.77
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.77	3.05
Physical effort required	2.05	2.14
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.86	3.00
Outcome depends on the skill and judgment of physician	2.86	3.09
Estimated risk of malpractice suit with poor outcome	2.95	2.95

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.59	2.86
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.17.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
33,000 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81243 Tracking Number M11 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old man with moderate mental retardation (IQ 50 - 60) of above average height with a long narrow face, close set eyes, a highly arched palate, a prominent mandible, joint laxity in his fingers, and macroorchidism, presents to a physician for evaluation for the etiology of his mental retardation. Although his mother was of normal intelligence, his family history was remarkable for having an 18-year-old sister with a mild learning disability, a maternal aunt with premature ovarian failure, and a 68-year-old maternal grandfather with a progressive neurological illness characterized by development of a tremor, followed by difficulties with balance and occasional falling. A previously performed karyotype was normal. A sample of anticoagulated peripheral blood is submitted to the laboratory for FMR1 gene testing.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic region containing the site of the CGG trinucleotide repeat region that is expanded in fragile X syndrome is amplified by using a PCR technique. The amplicon are then subjected to analysis using fluorescent capillary electrophoresis. The physician examines the electropherogram and compares it to a sizing ladder to determine the number of CGG repeats within the amplicon. Based on this analysis, the physician determines the patient's FMR1 allele status and whether additional characterization of alleles is necessary. He or she composes a report which specifies the patient's allele status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81243		
Sample Size:	450	**Resp N:** 13	**Response:** 2.8 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	50.00	**120.00**	300.00	500.00
Survey RVW:	0.20	0.37	**0.50**	0.55	0.60
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	8.00	**15.00**	15.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81243	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.31	**RUC Time**	1,231,072

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 61.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81243**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	4.00
Urgency of medical decision making	2.88	3.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.25	4.38
Physical effort required	2.88	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	4.00
Outcome depends on the skill and judgment of physician	3.88	4.13
Estimated risk of malpractice suit with poor outcome	3.63	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.75	4.00
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.37.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81244 Tracking Number M12 Original Specialty Recommended RVU: **0.51**
Presented Recommended RVU: **0.51**
Global Period: XXX RUC Recommended RVU: **0.51**

CPT Descriptor: FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a routine pediatric office visit, the mother of a 10-year-old girl describes what she considers to be unusual shyness leading to apparent social isolation, as well as occasional stereotypic behaviors such as hand wringing. The child attends regular school classes and her performance is somewhat below average. There is no family history of mental retardation or other neurologic problems. Both parents are healthy and of average intelligence and the patient has a 13-year-old brother who is otherwise healthy and performs well in school. The patient had a normal karyotype and array CGH study. FMR1 gene testing performed by gel-based PCR analysis revealed a single allele of normal CGG repeat size, but did not definitely show the presence of a second allele. A sample of anticoagulated peripheral blood is sent to the laboratory for Southern blot testing for fragile X syndrome utilizing a methylation specific enzyme.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, a large quantity of high quality genomic DNA is isolated. Gel electrophoresis of the extracted DNA is performed to assess DNA integrity. The DNA specimen undergoes double restriction digestion with the methylation-sensitive restriction enzyme EagI and the methylation-insensitive restriction enzyme EcoRI. The genomic fragments are separated by gel electrophoresis, transferred to a nylon membrane by capillary action, and hybridized to a labeled probe. The hybridization pattern is visualized on x-ray film by autoradiography. The physician examines the image, compares the observed fragments to a sizing ladder to estimate CGG repeat numbers, and analyzes the patterns generated to assess the methylation status of the promoter region of the expanded FMR1 allele. Based on this analysis the physiciandetermines the patient’s allele status, presence of expanded allele(s) and methylation status of the FMR1 promoter. He or she composes a report which specifies the patient's allele status, approximate allele sizes and promoter methylation status. The report is edited, signed and the results are communicated to the appropriate caregivers

CPT Code: 81244

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81244				
Sample Size:	450	**Resp N:**	11	**Response:** 2.4 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	32.50	**50.00**	185.00	300.00
Survey RVW:	0.37	0.51	**0.55**	0.63	0.85
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	12.00	**20.00**	22.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81244	**Recommended Physician Work RVU: 0.51**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,175,839

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	115,072

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surfacee

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 54.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81244**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**20.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.50
Urgency of medical decision making	2.67	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	3.17
Physical effort required	3.17	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	3.83
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.50	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.17	4.00
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.51.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81256 Tracking Number M13 Original Specialty Recommended RVU: **0.15**
Presented Recommended RVU: **0.13**
Global Period: XXX RUC Recommended RVU: **0.13**

CPT Descriptor: HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old man is found to have elevated transferrin saturation (65%) and ferritin (800 ng/mL) on routine testing. The patient is otherwise healthy, and his family history is unremarkable. A sample of anticoagulated peripheral blood is submitted to the laboratory for testing for the HFE p. C282Y (c.845G>A) and p. H63D (c.187 C>G) hereditary hemochromatosis mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic regions containing the sites of the HFE p. C282Y (c.845G>A) and p. H63D (c.187 C>G) mutations are amplified by PCR and the amplicons are then subjected to melting curve analysis. The physician examines the melting curve plot of red and green fluorescent signals vs. temperature as well as the plot of the negative first derivatives of red and green fluorescent signals vs. temperature. Based on the analysis of these curves, and comparison to the results obtained with wild type and mutant controls, the physician determines the status of the p. C282Y (c.845G>A) and p. H63D (c.187 C>G) mutations and determines the patient's status as homozygous, heterozygous, or compound heterozygous for each of these mutations. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81256		
Sample Size:	450	**Resp N:** 18	**Response:** 4.0 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	18.00	50.00	**100.00**	287.50	500.00
Survey RVW:	0.30	0.37	**0.37**	0.40	0.65
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**7.00**	12.00	15.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81256	**Recommended Physician Work RVU: 0.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95165	XXX	0.06	**RUC Time**	5,412,909

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73560	XXX	0.17	**RUC Time**	2,137,514

CPT Descriptor 2 Radiologic examination, knee; 1 or 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 55.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81256**	**Key Reference CPT Code:** 86320	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	7.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**7.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.30	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.30	2.70
Urgency of medical decision making	2.20	2.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.80	3.00
Physical effort required	2.30	2.30
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.50	2.80
Outcome depends on the skill and judgment of physician	2.50	2.70
Estimated risk of malpractice suit with poor outcome	2.70	2.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.60	2.70
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.15.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
15,000 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81270 Tracking Number M14 Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old man presents with headache, dizziness and hypertension. A CBC reveals hemoglobin of 20 g/dL and platelet count of 600,000/μL. The physician is concerned that the patient may have a myeloproliferative disorder such as polycythemia vera. A sample of anticoagulated peripheral blood is submitted to the laboratory for JAK2 V617F mutation detection.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality DNA is isolated. Allele specific, real time PCR utilizing hydrolysis probes is performed to amplify a short region spanning the mutation site. Following amplification, genotyping is performed by allelic discrimination, using a mixture of two probes, one of which is specific for the wild type gene, and the other specific for the mutant gene. The physicianl examines a graphical display of the fluorescence signal for the patient's sample, compares the results to mutant and wild type controls, and determines the status of the JAK2 mutant allele. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81270				
Sample Size:	450	**Resp N:**	46	**Response:** 10.2 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	46.25	**100.00**	200.00	550.00
Survey RVW:	0.10	0.37	**0.43**	0.52	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	7.00	**10.00**	15.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81270	**Recommended Physician Work RVU: 0.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,334,268

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 30.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 81270**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**10.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.57	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.93
Urgency of medical decision making	3.07	3.07
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.07
Physical effort required	2.07	2.36
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.07
Outcome depends on the skill and judgment of physician	2.93	3.07
Estimated risk of malpractice suit with poor outcome	3.21	3.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.71	2.93
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.22.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81275 Tracking Number M15 Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male patient presents with fatigue and weight loss. A full history and physical was performed and blood is discovered in the stool. Gastrointestinal endoscopic examination is performed and a large mass lesion in the sigmoid colon is found. Biopsies are taken and demonstrate a moderately differentiated adenocarcinoma of colonic origin. Subsequent radiologic studies identify possible enlarged lymph nodes in the region of the mass lesion. A resection is performed and metastases are identified. KRAS mutation testing is ordered as the patient is a potential candidate for targeted therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: DNA is extracted from a tumor tissue sample. PCR is performed to detect KRAS mutations in a background of wild-type DNA in 8 separate reactions utilizing fluorescent probe-linked primers specific for each of the seven most common mutations in codons 12 and 13 of exon 2 of the KRAS gene, as well as a control reaction that amplifies a region of KRAS exon 4. Thephysicianananalyzes the fluorescent curves that are produced as the PCR products are generated for each reaction. The physician assesses the amplification of internal controls in each reaction and compares the difference between the crossing thresholds of the mutation assay and the control assay to the establish mutation status. The physician composes a report which specifies the mutation status of the patient's tumor and includes a comment on the implications of the lower limit of detection of the test relative to the tumor content of the sample. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81275				
Sample Size:	450	**Resp N:**	43	**Response:** 9.5 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	29.00	**90.00**	171.50	650.00
Survey RVW:	0.35	0.50	**0.75**	1.00	1.52
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81275	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88363	XXX	0.37	**RUC Time**

CPT Descriptor Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,175,839

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,580,775

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 27.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 81275**	**Key Reference CPT Code:** 88363	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**17.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.25
Urgency of medical decision making	3.83	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.67
Physical effort required	3.42	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.58	3.33
Outcome depends on the skill and judgment of physician	3.58	3.42
Estimated risk of malpractice suit with poor outcome	3.42	3.42

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.67	3.58
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88363. The committee calculated an RVU based on using the median survey time and IWPUT for 88363. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.44.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81291 Tracking Number M16 Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old man developed a right femoral venous thrombosis following a 3-hour airplane flight and subsequently developed pulmonary emboli. There was a vague history of other family members having "clotting problems." His plasma homocysteine level was mildly elevated. A sample of anticoagulated peripheral blood is submitted to the laboratory for MTHFR c.677C>T and c.1298A>C mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic regions containing the sites of the MTHFR c.677C>T and c.1298A>C variants are amplified by multiplex PCR and the resulting amplicons subjected to melting curve analysis. The physician examines the melting curve plots of red and green fluorescent signals vs. temperature as well as the negative first derivative plots of the melting curves. Based on this analysis and comparison of results with appropriate controls, the physician etermines the zygosity status of the c.677C>T and c.1298A>C variants and composes a report specifying the patient's genotype. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP		
Specialty(s):	College of American Pathologists		
CPT Code:	81291		
Sample Size:	450	**Resp N:** 16	**Response:** 3.5 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	15.00	52.50	**125.00**	243.75	500.00
Survey RVW:	0.30	0.34	**0.37**	0.44	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	5.00	**10.00**	13.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81291	**Recommended Physician Work RVU: 0.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,334,268

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 62.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81291**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**10.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.50	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	3.30
Urgency of medical decision making	2.40	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.70	3.10
Physical effort required	2.20	2.30
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.60	3.20
Outcome depends on the skill and judgment of physician	2.70	3.10
Estimated risk of malpractice suit with poor outcome	2.76	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.80	3.10
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.22.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81315 Tracking Number M17 Original Specialty Recommended RVU: **0.39**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old previously healthy man presented to his physician complaining of fatigue, weakness, dyspnea, and easy bruising. He was found to have an elevated white blood count, anemia, and severe thrombocytopenia. The peripheral blood smear demonstrated large numbers of promyelocytes. Laboratory studies indicated DIC was present. The patient was emergently started on all trans-retinoic acid an anthracycline and supportive therapy for his coagulopathy. Bone marrow aspiration was performed, cytogenetic studies were ordered, and anticoagulated marrow was immediately sent to the laboratory for PML/RARalpha translocation testing by quantitative real-time PCR.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, total RNA is isolated and assessed for quality. Quantitative real-time reverse transcriptase PCR is performed in three separate tubes to detect and quantify the bcr1, bcr2, and bcr3 breakpoints as well as the Abelson gene (ABL1) in each tube. The physician analyzes the blue fluorescent curves that are produced as the PCR products are generated to determine the status of the translocation. He or she relates the crossing threshold to previously generated standard curves for the PML-RARA and ABL transcripts to determine the normalized and absolute copy numbers of the PML-RARA transcripts present in the specimen at the time of testing. The physician composes a report that describes the transcript status, the specific isoform, and the normalized copy number. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81315				
Sample Size:	450	**Resp N:**	27	**Response:** 6.0 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	6.00	20.00	**40.00**	50.00	200.00
Survey RVW:	0.20	0.51	**0.52**	0.61	0.95
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	8.00	**15.00**	23.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81315	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.31	**RUC Time**	1,231,072

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 44.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 81315**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	4.00
Urgency of medical decision making	4.58	3.92
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.83	4.08
Physical effort required	3.08	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.67	4.08
Outcome depends on the skill and judgment of physician	4.17	3.83
Estimated risk of malpractice suit with poor outcome	4.25	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.67	3.83
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code. The expert panel recommended an RVU of 0.39.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81316 Tracking Number M18 Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.22**
Global Period: XXX RUC Recommended RVU: **0.22**

CPT Descriptor: PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Quantitative PCR testing is requested on a 45-year-old man with an established diagnosis of acute promyelocytic leukemia to assess for treatment effectiveness and disease relapse. Anticoagulated marrow is sent to the laboratory for PML/RARalpha translocation testing for the previously identified breakpoint by quantitative real-time PCR.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, total RNA is isolated and assessed for quality. Quantitative real-time reverse transcriptase PCR is performed to detect and quantify the patient's specific breakpoint and the Abelson gene (ABL1). The physician analyzes the blue fluorescent curves that are produced as the PCR products are generated to determine the status of the translocation. He or she relates the crossing threshold to previously generated standard curves for the PML-RARA and ABL transcripts to determine the normalized and absolute copy numbers of the PML-RARA transcript present in the specimen at the time of testing. The physician composes a report that describes the transcript status and the normalized copy number, and compares these breakpoint specific results with the patient's previous results. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81316				
Sample Size:	450	**Resp N:**	15	**Response:** 3.3 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	13.50	**30.00**	45.00	80.00
Survey RVW:	0.20	0.37	**0.45**	0.57	0.80
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	8.00	**12.00**	18.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81316	**Recommended Physician Work RVU: 0.22**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**12.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81316**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	12.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**12.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.50
Urgency of medical decision making	4.33	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.83	3.50
Physical effort required	3.50	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.17	3.83
Outcome depends on the skill and judgment of physician	3.83	3.67
Estimated risk of malpractice suit with poor outcome	3.67	3.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.83	3.67
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.31.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 83912-26

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

Meeting Date: April 2011

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

CAP distributed practice expense surveys to various laboratories throughout the country, assuring that laboratories in various practice settings and sizes were included. The molecular pathologists and their lab managers (when applicable) submitted detailed practice expense recommendations to CAP for clinical labor, supplies, equipment and typical national batch size as well as the batch size in their particular laboratory.

CAP convened an expert panel, comprised of several molecular pathologists, members of the Economic Affairs Committee and the RUC subcommittee. The expert panel reviewed all the recommendations received. The panel adjusted the recommendations to adhere to applicable MoPath standards (i.e. confirm order, accession, extraction, set up, post time, etc). The panel also reviewed all the batch size data collected. The panel then made adjustments to clinical times, supplies and equipment based on batch size.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

We did not use a comparison code for these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical activities for these molecular pathology codes often fall into several broad subcategories. They include (when applicable):

- Confirm Orders
- Accession
- Extraction
- Set Up
- Gel
- Post Processing
- Review and Prepare

To facilitate review by the PEAC committee, we included broad categories of activities on the excel sheets. During our presentation we are prepared to walk the committee through the detail for each procedure, as requested. Although the activities fall into broad categories, the order and terminology is often different.

Below is a summary of our recommendations:

Tier	CPT Code	CPT Code Descriptor	Batch Size	Rec Times
Tier 1	BXXX2	*BCR/ABL 1; major breakpoint*	2	146
	BXXX3	*BCR/ABL 1; minor breakpoint*	1	176
	BXXX4	*BCR/ABL 1; other breakpoint*	1	176
	CXXX1	*CFTR (cystic fibrosis); common variants*	5	40
	CXXX2	*CFTR (cystic fibrosis); known familial variants*	1	211
	CXXX3	*CFTR (cystic fibrosis); duplication/deletion variants*	1	237
	CXXX4	*CFTR (cystic fibrosis); full gene sequence*	1	345
	CXXX5	*CFTR (cystic fibrosis); intron 8 poly-T analysis*	5	66
	FXXX1	*F2 gene analysis; 20210G>A variant*	5	39
	FXXX2	*F5 gene analysis; Leiden variant*	5	39
	FXXX4	*FMR1 (Fragile X mental retardation 1) gene analysis; evaluation to detect abnormal alleles*	5	67
	FXXX5	*FMR1 (Fragile X mental retardation 1) gene analysis; characterization of alleles*	1	174
	HXXX2	*HFE gene analysis; common variants*	5	68
	JXXX1	*JAK2 gene analysis; V617F variant*	3	116
	KXXX1	*KRAS gene analysis; variants in codons 12 and 13*	3	170
	MXXX2	*MTHFR gene analysis; common variants*	2	141
	PXXX1	*PML/RARalpha translocation analysis; common breakpoints*	1	150
	PXXX2	*PML/RARalpha translocation analysis; single breakpoints*	1	150

Tier	CPT Code	CPT Code Descriptor	Batch Size	Rec Times
Tier 2	L2XX1	*Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)*	2	89
	L2XX2	*Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)*	2	141
	L2XX3	*Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)*	2	182
	L2XX4	*Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicon using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)*	2	205
	L2XX5	*Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)*	1	217
	L2XX6	*Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)*	1	228
	L2XX7	*Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)*	1	250
	L2XX8	*Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)*	1	355
	L2XX9	*Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)*	1	455

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities:

- Enter results in lab information system after physician interpretation.
- Prepare, pack and transport specimens and records for in-house storage and external storage

- Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste
- Clean Room
- Perform station maintenance including system rinse and dry
- Perform scheduled data management back-up

April 20, 2011

Sherry L. Smith, MS, CPA
Director
Physician Payment Policy and Systems
American Medical Association
515 North State Street
Chicago, Illinois 60654

Dear Ms. Smith,

This letter is in follow up to our conversation from last week in which we discussed some of the concerns of the RUC's Practice Expense Subcommittee concerning the molecular pathology codes.

One area of concern of the subcommittee members pertained to who was involved in determining the practice expense inputs. From our molecular experts, we compiled a list of laboratories for each code that performed the various assays. The expert panel then selected one laboratory to recommend practice expense inputs for each code. The laboratories selected represented a full spectrum of laboratory sizes as well as practice types. Academic institutions as well as large commercial laboratories were also included in the laboratories that provided inputs. Each laboratory also indicated to us what their typical batch size was and also recommended a typical batch size for all laboratories performing the test for that code.

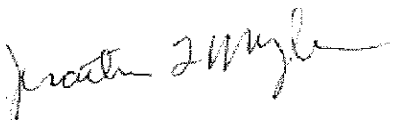
CAP's expert committee, which included members of our RBRVS workgroup as well as molecular experts, reviewed the practice expense inputs and batch sizes. Many of the steps are similar in various codes and allowed comparisons to be made. The batch sizes recommended to the RUC's Practice Expense Subcommittee from CAP were significantly larger than that recommended by the laboratories and the times for each step were typically a fraction of what the laboratory recommended.

In follow up to the Practice Expense Subcommittee's question concerning frequency, I indicated that in the existing coding scheme, it is not possible to reliably determine frequency data for the various codes. In fact, the AMA-CPT molecular pathology workgroup did investigate obtaining frequency data over a period of two years and ultimately concluded that reliable frequency data could not be obtained. Many laboratories would provide generalized percent distribution data, but would not provide specific numbers. However, the committee did conclude that the overwhelming highest volume test in frequency for molecular pathology was cystic fibrosis testing. This may not be applicable to the Medicare population. From review of the ICD 9 codes for the current way the professional services are coded (with CPT code 83912), it is not possible to reliably determine the frequency of molecular pathology codes under review. However, in our previous conversation, you indicated that the AMA would be willing to work with us using additional data available to the AMA to assist CAP in attempting to make this determination. For subcommittee guidance, anything with a batch size greater than two for any code listed in Tier 1 would be one of the higher frequency codes. Tier 2 codes are anticipated to be less than ten percent of total billed molecular pathology services and will not be considered high frequency codes. The batch size was increased in levels 1 through 4 to reduce times and maintain rank order with the rest of the Tier 2 codes.

I hope these comments have been helpful to you. Please do not hesitate to contact me if you have any questions.

Cordially,

,



Jonathan L. Myles, MD, FCAP
RUC Advisor
College of American Pathologists

jlm/kmc
Sent via email

Revised Total Clinical Labor time Tabs 15 and 16

AMA Specialty Society RVS Update Committee Recommendation

Tab 16: Tier 2 Codes				
CPT Code	**Original Rec Time**	**Revised Rec Time**	**Original Batch Size**	**Revised Batch Size**
81400	~~89~~	53	~~2~~	4
81401	~~141~~	75	~~2~~	4
81402	~~182~~	83	~~2~~	4
81403	~~205~~	102	~~2~~	4
81404	~~217~~	109	~~1~~	2
81405	~~228~~	118	~~1~~	2
81406	~~250~~	129	~~1~~	2
81407	~~355~~	158	~~1~~	2
81408	~~455~~	199	~~1~~	2
Tab 15: Tier 1 Codes				
81206	~~146~~	93	2	2
81207	~~176~~	86	~~1~~	2
81208	~~176~~	86	~~1~~	2
81220	~~40~~	29	~~5~~	10
81221	~~211~~	109	~~1~~	2
81222	~~237~~	107	~~1~~	2
81223	~~345~~	155	~~1~~	2
81224	~~66~~	29	~~5~~	10
81240	~~39~~	32	~~5~~	8
81241	~~39~~	32	~~5~~	8
81243	~~67~~	45	~~5~~	8
81244	~~174~~	80	~~1~~	2
81256	~~68~~	28	~~5~~	8
81270	~~116~~	37	~~3~~	5
81275	~~170~~	44	~~3~~	5
81291	~~141~~	64	~~2~~	4
81315	~~150~~	93	~~1~~	2
81316	~~150~~	93	~~1~~	2

	A	B	C	D	E	F
1	AMA Specialty Society RVS Update Committee Recommendation			**81206**	**81207**	**81208**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for batch size - 2*			*BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative*	*BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative*	*BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**93**	**86**	**86**
6	*Lab Tech*	*L033A*		*18*	*18*	*18*
7	*Cytotechnologist*	*L045A*		*75*	*68*	*68*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**82**	**74**	**74**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**					
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**
11	**PRE-SERVICE**					
12	**Start: When preparing containers/requisitions for physician begins**					
13	**Confirm** orders	L033A	Lab Tech	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6	6
15	Perform White Cell Count to prepare for RNA Extraction	L045A	Cytotechnologist	2	2	2
16	Reagent preparation for RT, pcr, CE	L045A	Cytotechnologist	7	7	7
17	Remove Buffy Coat	L045A	Cytotechnologist	2	2	2
18	Red Cell Lysis	L045A	Cytotechnologist	6	6	6
19	RNA Extraction Trizol method	L045A	Cytotechnologist	12	12	12
20	Perform OD / Calculate Quantity	L045A	Cytotechnologist	3	3	3
21	Gel Preparation and load QC Gel to confirm quality RNA	L045A	Cytotechnologist	9	9	9
22	cDNA Synthesis / Reverse Transcription	L045A	Cytotechnologist	10	10	10
23	Prepare worksheet to set up pcr / calculate mastermix, cDNA, etc.	L045A	Cytotechnologist	3	3	3
24	Set Up PCR	L045A	Cytotechnologist	9	9	9
25	Load Real time instruments	L045A	Cytotechnologist	2	0	0
26	Dilute Sample twice to prepare for capillary electrophoresis	L045A	Cytotechnologist	5	0	0
27	Load on Capillary Electrophoresis to identify transcript type	L045A	Cytotechnologist	2	2	2
28	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2	2
29	**End: When specimen is ready for examination by physician**					
30	**Service Period**					
31				**None**		
32	**Post-Service Period**					
33	**Start: When specimen examination by physician is complete**					
34	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2
35	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2
36	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2
37	Clean Room	L033A	Lab Tech	2	2	2
38	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2
39	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1
40	**End: When specimen, chemical waste and record handling is complete**					
41	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**	**No. of Units**
42	RNA isolation kit		kit	0.04	0.04	0.04
43	Gown	SB027	item	2	2	2
44	Gloves		pair	5	5	5
45	Bleach 10%	SL020	ml	5	5	5
46	1.5 ml tube		each	4	4	4
47	100 ml TAE Buffer		ml	100	100	100
48	10mM dNTPs		ul	7	7	7
49	2 Forward Primers		ul	16	16	16
50	5x Buffer		ul	13	13	13
51	96 well plate (2)		each	4	4	4
52	ABL Probe		ul	1	1	1
53	Agarose		Gram	1	1	1
54	bcr/abl Probe		ul	1	1	1
55	Blue Gel Dye		ul	9	9	9
56	CST ROX Size standard		ul	0.2	0	0
57	DEPC treated water		ul	30	30	30
58	Disposable lab coat x 2		each	2	2	2
59	Ethidium Bromide		ul	5	5	5
60	Eye Shield	SM016	each	1	1	1
61	Formamide x 2		ul	20	0	0
62	Internal Control Forward Primer		ul	0.5	0.5	0.5
63	Internal Control Reverse Primer		ul	0.5	0.5	0.5
64	Random hexamers		ul	7	7	7
65	Reverse Primers		ul	8	8	8
66	RNASse 40 u/ul		ul	1	1	1
67	Running Buffer		ul	80	0	0
68	Superscript		ul	2	2	2
69	Tips		pack	1	1	1
70	Tubes		each	10	10	10
71	Universal Master Mix		ul	25	25	25
72						
73	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
74	Analytical balance	EP004		1	1	1
75	Capillary electrophoresis instrument, fragment analysis			30	0	0
76	Centrifuge	EP059		3	3	3
77	Cooling block			3	3	3
78	Gel electrophoresis apparatus with power supply	EP063		15	15	15
79	Gel imaging system	EP062		4	4	4
80	Nucleic acid extraction Instrument			9	9	9
81	Nucleic acid workstation			15	15	15
82	Pipet Set	E071		25	25	25
83	Real-time PCR instrument			23	23	23
84	Thermal cycler			30	30	30
85	Water bath	EP043		10	10	10

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81220**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 10*		*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**29**
6	*Lab Tech*	*L033A*		*16*
7	*Cytotechnologist*	*L045A*		*13*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**20**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**9**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	Receiving sample, checking for unacceptable conditions: clotted or frozen, serum, severely hemolyzed samples			
16	Create patient list for testing			
17	Family history entry and check, to determine if there is known familial mutations requested			
18	**EXTRACTION**	L045A	Cytotechnolog	4
19	Extraction Set up: prepare load list on instrument, print work list and label, resolve all specimen discrepancies and label specimen tubes accordingly, preparing sample extraction reagents			
20	Load extraction reagents, micro particles, etc in reagents vessels on the instrument, put samples in the sample rack and load onto m2000sp			
21	Instrument Clean up after extraction is completed: bleach sample racks, wipe with bleach workbench on m2000sp, clean up reaction wells, reagent vessel holders			
22	**PCR / OTHER PROCESSES**	L045A	Cytotechnolog	4
23	Collect all PCR Master mix reagents, thaw; Fill out Master mix worksheet to calculate reagent needed for the number of samples in the run; Prepare master mix for the run,			
24	Label PCR tubes for patients and controls; Pipette patient samples into prepared PCR tubes; Preparing PCR plate by aliqouting Master mix into each sample tube/well. Seal PCR plate/tube, put in cycler and run PCR program			
25	Set up Amplicon Treatment reagent and pipette to PCR Plate			
26	Prepare ASPE master mix worksheet and calculate reagent amount for the number of samples; Prepare multiplex ASPE Primer mix and ASPE master mix			
27	Aliquot ASPE master mix into each sample tube/well. Seal the Plate, and put back into cycler and run ASPE program on the cycler			
28	Work list prep			
29	**DETECTION / HYBRIZATION**	L045A	Cytotechnolog	3
30	Luminex Set up, turn on instrument, check fluid levels in the sheath fluid box and waster reservoir, change if needed; Collect beads and prepare 1X wash buffer for bead hybridization;			
31	Add beads to samples post ASPE reaction, seal plates and hybrization in cycler for 1 Hybridization to beads, wash with wash buffer using vacuum manifold, repeat wash for a second time			
32	Add SA-PE conjugate to the samples post bead hybridization and wash.			
33	Data acquisition on Luminex analyzer: setting up instrument run, reagent lot number, Prepare tray map on Luminex 200, enter patient samples IDs and controls; adjust probe height, flush instrument, load plate and run			
34	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnolog	2
35	**End: When specimen is ready for examination by physician**			
36	**Post-Service Period**			
37	**Start: When specimen examination by physician is complete**			
38	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
39	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
40	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
41	Clean Room	L033A	Lab Tech	1
42	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
43	Perform scheduled data management back-up	L033A	Lab Tech	1
44	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81220**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 10*		*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	
3		**CMS Code**	**Staff Type**	**Minutes**
45	**SUPPLIES**		**Type of Unit**	**No. of Units**
46	0.2 ml PCR tube		item	6
47	1.5ml tubes	SL240	item	2
48	Bleach	SL020	mL	1
49	Blood collection (6mL, purple top)	SL242	unit	1
50	DNA extraction instrument pipette tips		item	42
51	DNA extraction instrument reagent kit		reaction	1
52	gloves, non-sterile, nitrile	SB023	item	1
53	High fidelity taq polymerase		µL	2
54	Labels		item	27
55	Microseal		item	1
56	Multichannel pipette tips		item	3
57	Multiplates		item	1
58	optical Ind Flat 8/cap strip		item	1
59	Paper		item	6
60	PCR and APSE WATER	SL2521	µL	24
61	Pipette tips, 100ul		item	3
62	Pipette tips, 10ul		item	7
63	Pipette tips, 200ul		item	3
64	Pipette tips, 30ul		item	3
65	Synthetic Super Control		item	1
66	xMAP Sheath Fluid		L	1
67	xTAG CF reagent kit		item	1
68				
69	**Equipment**			**Time in Use Minutes**
70	Centrifuge		EP059	9
71	Cooling block			3
72	Luminex Instrument			3
73	Micro-volume spectrophotometer with specimen retention technology			1
74	Nucleic acid extraction instrument			5
75	Nucleic acid workstation			4

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81221**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Typical Batch Size - 2*			*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; known familial variants
3		**CMS Code**	**Staff Type**	**Total Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*			*18*
7	*Cytotechnologist*			*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	sort and rack specimen according to test requested			
17	place blood sample on rocker			
18	Place tips and microtiter plate on Qiagen 9604			
19	Remove cap from blood tube			
20	place blood sample in Qiagen 9604 rack and allow instrument to read bar code and aliquot blot into microtiter plate			
21	Create plate map for testing and IT interface			
22	Cap blood tube and return specimen to refrigerator until testing completed			
23	Place tips, reagents and microtiter plates on Qiagen M96			
24	Place microtiter plate with blood sample on Qiagen M96			
25	discard DNA extraction waste (liquids and solids)			
26	**PCR Set Up**			13
27	Assemble PCR Primers, buffer, etc… into plates			
28	combine reagents for PCR master mix			
29	Place tips, PCR reagents and PCR reaction plate on Biomek 2000			
30	Remove extracted DNA from Qiagen M96 and place on Biomek 2000			
31	Allow instrument to set up PCR reaction			
32	Cover plate with sealing mat			
33	discard Biomek 2000 tips from PCR set up			
34	Place PCR reaction plate in ABI 9700 thermal cycler, enter CF PCR program, and allow instrument to perform multiplex PCR			
35	Cover plate with sealing mat			
36	discard Biomek 2000 tips from PCR set up			
37	**Gel Check**	L045A	Cytotechnologist	13
38	Spin down PCR plate (Gel Check)			
39	Combine 2ul of Sample with 10 ul water (Gel Check)			
40	Add samples to E-Gel			
41	Photograph Gel			
42	Save Image and Annotate			
43	**PCR Post Processing 1**	L045A	Cytotechnologist	17
44	Create CIAP/EXO Mix			
45	Add Mix to plate			
46	Add samples to mix			
47	Place on 9700 Cycler			
48	**Dye Term Cycle**	L045A	Cytotechnologist	13
49	Prepare Sequencing plates			
50	Prepare Sequencing Big Dye Master Mix			
51	Aliquot Big Dye master mix			
52	Add template			
53	Seal, vortex, spin			
54	Place on 9700 Cycler			
55	**Dye Term Clean Up**	L045A	Cytotechnologist	24
56	Make fresh Sodium Acetat/ETOH			
57	Add to Sequencing Samples			
58	Spin Down for 20 min			
59	Invert plate on towels			
60	Quick spin plate			
61	Make fresh 70% ETOH			
62	Add ETOH to wells			
63	Spin for 5 min			
64	Quick spin plate			
65	Add Hi Di and Seq Standard			
66	Add Hi Di and Seq Standard			
67	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure “OUT” stack is empty			
68	**Sequencing**	L045A	Cytotechnologist	5
69	Load plate onto sequencer			
70	Create new sample sheet using batch name/sample number			
71	Check capillary array after run is completed			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81221**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Typical Batch Size - 2*			*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; known familial variants
3		**CMS Code**	**Staff Type**	**Total Minutes**
72	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
73	**End: When specimen is ready for examination by physician**			
74	**Service Period**			
75				
76	**Post-Service Period**			
77	**Start: When specimen examination by physician is complete**			
78	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
79	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
80	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
81	Clean Room	L033A	Lab Tech	2
82	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
83	Perform scheduled data management back-up	L033A	Lab Tech	1
84	**End: When specimen, chemical waste and record handling is complete**			
85	**SUPPLIES**		**Type of Unit**	**No. of Units**
86	DNA isolation kit		reaction	1
87	Gown	SB027	item	1
88	Gloves, nonsterile	SB022	pair	5
89	Bleach 10%	SL020	ml	1.5
90	High fidelity hot start Taq polymerase		ul	0.5
91	PCR buffer		ul	10
92	MgCl2		ul	3
93	F Primer		ul	2
94	R Primer		ul	2
95	dNTPs		ul	2
96	PCR grade water	SL244	ul	68
97	Ethidium bromide (10 mg/ml)	SL239	ul	5
98	DNA ladder, 100bp		ul	5
99	Loading buffer with dye	SL210	ul	20
100	Agarose ultrapure		g	0.8
101	Agarose NuSieve GTG		g	1.6
102	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
103	Masking tape		inch	12
104	96 Capillary array		item	1/200
105	Cycle sequencing kit		ul	16
106	Cycle sequencing purification plates		each	1
107	Optical 96 well reaction plate		each	1
108	Sequencing primers		ul	4
109	0.2 ml strip tubes		each	1
110	0.2 ml PCR tubes		each	2
111	Barrier pipet tips1000 uL		ul	1
112	Barrier pipet tips 200 uL		each	3
113	Barrier pipet tips 20uL		each	15
114	Milli-Q water		ml	35
115	Exonuclease I / Shrimp alkaline phosphatase		ul	4
116	Formamide	SL192	ul	30
117	Septa		each	0.3
118	Polymer		ul	1/125
119	Sequencing cassette		each	1
120	Running buffer		ul	80
121	15 mL centrifuge tubes	SL241		2
122	50 mL centrifuge tubes			2
123	2 mL plastic tubes		each	1
124	0.5 mL microcentrifuge tubes			2
125	Extraction tubs		each	4
126	Extraction tip assembly		each	1
127				
128	**Equipment**			**Time in Use Minutes**
129	Analytical balance		EP004	1
130	Capillary electrophoresis instrument, 96 well - sequencing			12
131	Centrifuge		EP059	3
132	Cooling block			3
133	Gel electrophoresis apparatus with power supply		EP063	15
134	Gel imaging system		EP062	4
135	Micro-volume spectrophotometer with specimen retention technology			1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81222**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Typical Batch Size - 2*		*CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants*	
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**107**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*89*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**96**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	sort and rack specimen according to test requested			
17	place blood sample on rocker			
18	Place tips and microtiter plate on Janus PE			
19	Remove cap from blood tube			
20	Check the reagent levels.			
21	Check the waste container level.			
22	Verify availability of all necessary disposables			
23	Write ID # in the input tube (red cap) and output tube (blue cap).			
24	Confirm that Autopure LS, and computer are powered on.			
25	Confirm the system waste bottle is not full.			
26	Verify ID number on sample tube matches ID number on aliquot tube and transfer blood to input tube.			
27	Place samples into appropriate position in sample racks and verify that the input tube matches the output tube.			
28	Place sample racks into appropriate position on deck surface of Autopure LS.			
29	Enter user ID, password and log on.			
30	Initialize and Prime for the reagents			
31	On main menu start your run by clicking on “set up rack” and follow through.			
32	Enter the ID # for input and output tubes on the computer.			
33	Click on “select rack” and “start run”.			
34	After run, remove tubes from Autopure, discard input tubes			
35	Place output tubes in 65°C incubator for 1 hr			
36	Remove tubes, place them on a platform to rotate overnight at room tenperature .			
37	Place DNA output tubes in numerical order			
38	Transfer DNA to labeled 1.5 ml tubes.			
39	Pipette with 1ml pipette tip to completely dissolve DNA			
40	Quant on Flourometer or Spectramax. Remix, dilute and requant as necessary.			
41	Label side of tube with quant			
42	Place DNA in appropriate box.			
43	discard DNA extraction waste (liquids and solids)			
44	**PCR Set Up**	L045A	Cytotechnologist	28
45	Place tips, PCR reagents and PCR reaction plate into the hood.Prepare the PCR master mix.			
46	Add the master mix to the reagent plate			
47	Using extracted DNA make nessesary dilutions			
48	Add extracted DNA & control per well per sample			
49	Set up PCR reaction			
50	Cover plate with sealing mat, vortex and spin down in the plate centrifuge			
51	Place PCR reaction plate in ABI 9700 thermal cycler, enter CFDel/Dup PCR program, and allow instrument to perform multiplex PCR			
52	**PCR Post Processing**	L045A	Cytotechnologist	55
53	Pull the PCR reaction plate out of ABI 9700 thermal cycler to be stored or to proceed with next step			
54	Pull the loading mix reagents (HiDi Formamide and GeneScan 350 ROX Size Standard) out of the freezer, let them thaw out			
55	Make the loading mix by combining HiDi formamide and GeneScan 350 ROX Size Standard			
56	Spin down a PCR plate			
57	Add a loading mix into each well of an ABI optical plate			
58	Add pcr product to each well			
59	Cover the plate with septa and vortex the loading tray, and then spin down in the plate centrifuge.			
60	Place the plate in 95°C heat block for 5 minutes, then place on ice until use			
61	Prepare 3100 instrument for capillary electrophoresis (upload plate map, add buffer, POP6, capillary array, 16-well septa)			
62	Generate the plate record with template in Excel			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81222**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Typical Batch Size - 2*		*CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants*	
3		**CMS Code**	**Staff Type**	**Minutes**
63	Configure the plate in 3100 collection software with the run parameters, start the run			
64	Allow instrument to perform capillary electrophoresis			
65	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
66	**End: When specimen is ready for examination by physician**			
67	**Service Period**			
68				
69	**Post-Service Period**			
70	**Start: When specimen examination by physician is complete**			
71	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
72	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
73	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
74	Clean Room	L033A	Lab Tech	2
75	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
76	Perform scheduled data management back-up	L033A	Lab Tech	1
77	**End: When specimen, chemical waste and record handling is complete**			
78	**SUPPLIES**		**Type of Unit**	**No. of Units**
79	DNA isolation kit		reaction	1
80	10% bleach solution	SL020	ml	1.5
81	100% ethanol	SL189	ml	0.44
82	10x Buffer		ul	0.007
83	1-30ul pipet tips		each	5
84	16-well reservoir septa		each	0.06
85	25 mL pipettes		item	1
86	8-cap strips		each	0.13
87	8-strip tubes/caps		each	0.035
88	96-well septa		each	0.01
89	Barrier pipet 1000 tips		each	1
90	Barrier pipet 200 tips		each	2
91	cap for blood tube		each	1
92	Capillary array		item	1
93	DNA extraction instrument tips		item	6
94	DNA/RNase-free H2O	SL251	ul	20
95	Formamide	SL192	ml	0.012
96	gloves, nonsterile	SB022	item	1
97	gown, staff, impervious	SB027	item	0.5
98	green microtiter plates		each	0.01
99	High fidelity taq polymerase fast start		ul	0.2
100	High fidelity taq polymerase hot start		ul	0.1
101	Liquid handling system tips		item	1
102	Matrix Standard		ul	0.56
103	OLIGOs for PCR		item	30
104	optical plates, 96-well		each	0.02
105	PCR plates		each	0.01
106	Pipet Ser Dsp 10X1/10Ml		item	1
107	Polymer		ul	10
108	sealing mat		each	0.01
109	Titer Tops plate sealers		item	0.011
110	U bottom microtiter plates		each	0.01
111	yellow microtiter plates		each	0.01
112				
113	**Equipment**			**Time in Use Minutes**
114	Capillary electrophoresis fragment analysis software			30
115	Capillary electrophoresis instrument, fragment analysis			30
116	Centrifuge		EP059	3
117	Cooling block			3
118	Micro-volume spectrophotometer with specimen retention technology			1
119	Nucleic acid extraction instrument			5
120	Nucleic acid workstation			28

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81223**
2	**Meeting Date: April 2011** *Typical Batch Size - 2*			*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; full gene sequence
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**155**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*137*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**144**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	Confirm orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	6
16	sort and rack specimen according to test requested			
17	place blood sample on rocker			
18	Place tips and microtiter plate on Qiagen 9604			
19	Remove cap from blood tube			
20	place blood sample in Qiagen 9604 rack and allow instrument to read bar code and aliquot blot into microtiter plate			
21	Create plate map for testing and IT interface			
22	Cap blood tube and return specimen to refrigerator until testing completed			
23	Place tips, reagents and microtiter plates on Qiagen M96			
24	Place microtiter plate with blood sample on Qiagen M96			
25	discard DNA extraction waste (liquids and solids)			
26	Assemble PCR Primers, buffer, etc… into plates			
27	combine reagents for PCR master mix			
28	**PCR Set Up**	L045A	Cytotechnologist	36
29	Place tips, PCR reagents and PCR reaction plate on Biomek 2000			
30	Remove extracted DNA from Qiagen M96 and place on Biomek 2000			
31	Allow instrument to set up PCR reaction			
32	Cover plate with sealing mat			
33	discard Biomek 2000 tips from PCR set up			
34	Place PCR reaction plate in ABI 9700 thermal cycler, enter CF PCR program, and allow instrument to perform multiplex PCR			
35	Cover plate with sealing mat			
36	discard Biomek 2000 tips from PCR set up			
37	**Gel Check**	L045A	Cytotechnologist	20
38	Spin down PCR plate (Gel Check)			
39	Combine 2ul of Sample with 10 ul water (Gel Check)			
40	Add samples to E-Gel			
41	Photograph Gel			
42	Save Image and Annotate			
43	**PCR Post Processing 1**	L045A	Cytotechnologist	18
44	Create CIAP/EXO Mix			
45	Add Mix to plate			
46	Add samples to mix			
47	Place on 9700 Cycler			
48	**Dye Term Cycle**	L045A	Cytotechnologist	20
49	Prepare Sequencing plates			
50	Prepare Sequencing Big Dye Master Mix			
51	Aliquot Big Dye master mix			
52	Add template			
53	Seal, vortex, spin			
54	Place on 9700 Cycler			
55	**Dye Term Clean Up**	L045A	Cytotechnologist	30
56	Make fresh Sodium Acetat/ETOH			
57	Add to Sequencing Samples			
58	Spin Down for 20 min			
59	Invert plate on towels			
60	Quick spin plate			
61	Make fresh 70% ETOH			
62	Add ETOH to wells			
63	Spin for 5 min			
64	Quick spin plate			
65	Add Hi Di and Seq Standard			
66	Cover with Septa/Quick Spin			
67	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure “OUT” stack is empty			
68	**Sequencing**	L045A	Cytotechnologist	5
69	Load plate onto sequencer			
70	Create new sample sheet using batch name/sample number			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81223**
2	**Meeting Date: April 2011** *Typical Batch Size - 2*			*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; full gene sequence
3		**CMS Code**	**Staff Type**	**Minutes**
71	Check capillary array after run is completed			
72	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
73	**End: When specimen is ready for examination by physician**			
74	**Service Period**			
75				
76	**Post-Service Period**			
77	**Start: When specimen examination by physician is complete**			
78	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
79	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
80	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
81	Clean Room	L033A	Lab Tech	2
82	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
83	Perform scheduled data management back-up	L033A	Lab Tech	1
84	**End: When specimen, chemical waste and record handling is complete**			
85	**SUPPLIES**		**Type of Unit**	**No. of Units**
86	DNA isolation kit		reaction	1
87	Gown	SB027	item	1
88	Gloves, nonsterile	SB022	pair	5
89	Bleach 10%	SL020	ml	1.5
90	High fidelity hot start Taq polymerase		ul	13.5
91	PCR buffer		ul	270
92	MgCl2		ul	81
93	F Primer X 27		ul	2
94	R Primer X 27		ul	2
95	dNTPs		ul	54
96	PCR grade water	SL244	ul	1836
97	Ethidium bromide (10 mg/ml)	SL239	ul	10
98	DNA ladder, 100bp		ul	10
99	Loading buffer with dye	SL210	ul	40
100	Agarose ultrapure		g	1.6
101	Agarose NuSieve GTG		g	3.2
102	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	200
103	Masking tape		inch	24
104	96 Capillary array		item	1/200
105	Cycle sequencing kit		ul	432
106	Cycle sequencing purification plates		each	1
107	Optical 96 well reaction plate		each	1
108	Sequencing primers		ul	108
109	0.2 mL strip tubes		each	6
110	0.2 ml PCR tubes		each	28
111	Barrier pipet tips1000 uL		ul	5
112	Barrier pipet tips 200 uL		each	50
113	Barrier pipet tips 20uL		each	405
114	Milli-Q water		ml	35
115	Exonuclease I / Shrimp alkaline phosphatase		ul	4
116	Formamide	SL192	ul	30
117	Septa		each	0.3
118	Polymer		ul	1/125
119	Sequencing cassette		each	1
120	Running buffer		ul	80
121	15 mL centrifuge tubes	SL241		2
122	50 mL centrifuge tubes			2
123	2 mL plastic tubes		each	28
124	0.5 mL microcentrifuge tubes			34
125	Extraction tubs		each	4
126				
127	**Equipment**			**Time in Use Minutes**
128	Analytical balance		EP004	2
129	Capillary electrophoresis instrument, 96 well sequencing			72
130	Centrifuge		EP059	3
131	Cooling block			3
132	Gel electrophoresis apparatus with power supply		EP063	15
133	Gel imaging system		EP062	8
134	Micro-volume spectrophotometer with specimen retention technology			1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81224**	
2	**Meeting Date: April 2011** *Adjusted for Batch Size - 10*		*CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)*	
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**29**
6	*Lab Tech*	*L033A*		*16*
7	*Cytotechnologist*	*L045A*		*13*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**20**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**9**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set Up	L045A	Cytotechnologist	2
17	PCR Gel	L045A	Cytotechnologist	2
18	PCR Post Processing	L045A	Cytotechnologist	3
19	**Review sample and prepare data for interpretation**	L045A	Cytotechnologist	2
20	Review sample			
21	Print/prepare results for medical director review			
22	**End: When specimen is ready for examination by physician**			
23	**Service Period**			
24				
25	**Post-Service Period**			
26	**Start: When specimen examination by physician is complete**			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	1
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	**End: When specimen, chemical waste and record handling is complete**			
34	**SUPPLIES**		**Type of Unit**	**No. of Units**
35	0.2 ml PCR tube		item	6
36	1.5ml tubes	SL240	item	2
37	Bleach	SL020	mL	1
38	Blood collection (6mL, purple top)	SL242	unit	1
39	DNA extraction instrument pipette tips		item	42
40	DNA extraction instrument reagent kit		reaction	1
41	gloves, non-sterile, nitrile	SB023	item	1
42	gown, staff, impervious	SB027	unit	0
43	High fidelity taq polymerase		µL	2
44	Labels		item	27
45	Microseal		item	1
46	Multichannel pipette tips		item	3
47	Multiplates		item	1
48	optical Ind Flat 8/cap strip		item	1
49	Paper		item	6
50	PCR and APSE WATER	SL251	µL	24
51	Pipette tips, 100ul		item	3
52	Pipette tips, 10ul		item	7
53	Pipette tips, 200ul		item	3
54	Pipette tips, 30ul		item	3
55	Synthetic Super Control		item	1

	A	B	C	D
56	xMAP Sheath Fluid		L	1
57	xTAG CF reagent kit		item	1
58				
59	**Equipment**			**Time in Use Minutes**
60	Centrifuge		EP059	3
61	Cooling block			9
62	Luminex instrument			3
63	Micro-volume spectrophotometer with specimen retention technology			1
64	Nucleic acid extraction instrument			5
65	Nucleic acid workstation			4
66	Pipet set		EP071	5
67	Sonicator bath			3
68	Thermal cycler			10
69	Water bath		EP043	10

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			**81240**	**81241**
2	**Meeting Date: April 2011** *Adjusted for Batch Size - 8*			*F2 gene analysis; 20210G>A variant*	*F5 gene analysis; leiden variant*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**32**	**32**
6	*Lab Tech*	*L033A*		*16*	*16*
7	*Cytotechnologist*	*L045A*		*16*	*16*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**23**	**23**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**9**	**9**
11	**PRE-SERVICE**				
12	**Start: When preparing containers/requisitions for physician begins**				
13	**Confirm** orders	L033A	Lab Tech	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
15	Arrange consumables for extraction	L045A	Cytotechnologist	2	2
16	Load samples into sample cartridge	L045A	Cytotechnologist	1	1
17	Extraction on MagnaPure			0	0
18	Create master mix protocols and LightCycler worklists	L045A	Cytotechnologist	2	2
19	Prepare master mix in dead air box	L045A	Cytotechnologist	3	3
20	Transfer extracted DNA into tubes	L045A	Cytotechnologist	1	1
21	Set up LightCycler carousel	L045A	Cytotechnologist	2	2
22	Complete Helix extraction and master mix protocols in LIS	L045A	Cytotechnologist	1	1
23	Perform self-test on LightCycler and load files onto instrument	L045A	Cytotechnologist	1	1
24	Centrifuge carousel and load run	L045A	Cytotechnologist	1	1
25	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
26	**End: When specimen is ready for examination by physician**				
27	**Service Period**				
28					
29	**Post-Service Period**				
30	**Start: When specimen examination by physician is complete**				
31	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
32	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1	1
33	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
34	Clean Room	L033A	Lab Tech	1	1
35	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
36	Perform scheduled data management back-up	L033A	Lab Tech	1	1
37	**End: When specimen, chemical waste and record handling is complete**				
38	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
39	DNA isolation kit		reaction		1
40	Gown	SB027	item	0.25	0.25
41	Bleach 10%	SL020	ml	0.375	0.375
42	Extraction tip assembly		each	1	1
43	Extraction tubs		each	4	4
44	Barrier pipet tips 1000 uL		each	2	2
45	2 plastic tubes (1 1.5mL/1 2.0mL)		item	5	5
46	20 µL barrier pipe tips		item	4	4
47	200 µL barrier pipet tips		item	4	4
48	25mL serological pipettes		item	2	2
49	5mL serological pipettes		item	3	3
50	Bench paper		meter	0.1875	0.1875
51	Bouffant hats (pre and post)	SB001	item	0.25	0.25
52	DRF water	SL251	mL	3	3
53	drop catcher		item	1	1
54	gloves, nonsterile, nitrile	SB023	pairs	0.75	0.75
55	large reagent tubs/lids		item	2	2
56	LightCybler Factor II (Prothrombin) G20210A Kit		reactions	1	-
57	LightCycler Factor V Leiden Kit (30 reactions per kit)		reactions	-	1
58	medium reagent tubs/lids		item	4	4
59	Plastic bags (various sizes)		item	3	3
60	Plastic tubes		item	1	1
61	processing cartridges		item	2	2
62	Real-time PCR instrument capillaries		item	1	1
63	sample cartridges		item	3	3
64	Shoe covers (pre and post)	SB039	pairs	0.25	0.25
65	Tip stand		item	1	1
66	High fidelity hot start Taq polymerase		ul	0.375	0.375
67					
68	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
69	Micro-volume spectrophotometer with specimen retention technology			1	1
70	Nucleic acid extraction instrument			5	5
71	Nucleic acid workstation			2	2
72	Pipet set		EP071	2	2
73	Real-time PCR instrument			6	6

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81243**	
2	**Meeting Date: April 2011** *Adjusted for Batch Size - 8*		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**45**
6	*Lab Tech*	*L033A*		*16*
7	*Cytotechnologist*	*L045A*		*29*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**36**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**9**
11	**PRE-SERVICE**			
12	**Confirm** orders	L033A	Lab Tech	1
13	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
14	Retrieve and accession specimen: Receiving sample, checking for unacdeptable conditions: clotted or frozen, serum, serverely hemolyzed samples, green top heparin (contains preservative that interfer with PCR)			
15	Gather all prior reports and history on the patient: enter reason for testing, gender of patient, family history of fragile X or autism-spectrum disease, etc.			
16	Check blood tube against requisition			
17	Log in patient with accession ID, create patient list for testing			
18	Print out labels			
19	Setup extraction labels			
20	**Extraction**	L045A	Cytotechnologist	4
21	Gather all needed cartriages, internal control, and elution tubes, reagents and racks. Inspect cartriage integrity and fill volume in wells.			
22	Label and Load 1.5ml sample tube and elution tube for Compact MagNAPure Compact			
23	Load onto Compact, set up Compact run conditions, and run			
24	Check DNA concentratoin and 260/280 ration on NanoDrop			
25	**PCR**	L045A	Cytotechnologist	6
26	Label Patient tubes (for dilution)			
27	Dilute DNA			
28	Prepare master mix			
29	Label 2 -8 tube strips			
30	Aliquot master mix			
31	Add diluted DNA			
32	Cap strips			
33	Place on PCR machine and start program			
34	PCR clean up			
35	**PCR Gel**	L045A	Cytotechnologist	6
36	Prepare Gel			
37	Mix samples with dye			
38	Load gel			
39	Gel picture			
40	Label picture			
41	**PCR Injection, Detection onto Genetic Analyzer**	L045A	Cytotechnologist	11
42	Label 2 -8 tube strips			
43	Dilute PCR			
44	Prepare master mix			
45	Prepare PCR plate: Aliquot PCR master mix into each PCR tube/well; Add patient sample into each PCR tube/cell			
46	Cap strips			
47	Place on PCR machine to denature + start program			
48	Place on ice			
49	Prepare plate map for injection with patient ID			
50	Setting up run module conditions and start run			
51	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
52	**End: When specimen is ready for examination by physician**			
53	**Service Period**			
54				
55	**Post-Service Period**			
56	**Start: When specimen examination by physician is complete**			
57	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
58	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
59	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
60	Clean Room	L033A	Lab Tech	1
61	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
62	Perform scheduled data management back-up	L033A	Lab Tech	1
63	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81243**	
2	**Meeting Date: April 2011** *Adjusted for Batch Size - 8*		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	
3		**CMS Code**	**Staff Type**	**Minutes**
64	**SUPPLIES**		**Type of Unit**	**No. of Units**
65	DNA isolation		reaction	1
66	Bleach 10%	SL020	ml	0.375
67	Extraction tip assembly		each	1
68	Extraction tubs		each	4
69	High fidelity hot start Taq polymerase		ul	.0.375
70	Milli-Q water		ml	35
71	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
72	Masking tape		inches	12
73	0.5mL tubes		item	4.71
74	1.5 mL tubes	SL240	item	1.18
75	DNA LADDER,100 BP		uL	2.35
76	AGAROSE		g	1.76
77	ASR Primers for FMR1		mcL	0.94
78	ASR Primers for Gender		mcL	0.71
79	Blood collection (6mL, purple top)	SL242	unit	1.18
80	Buffer for genetic analyzer		mL	11.76
81	Capillary array		item	1.18
82	Cleanup Enzyme Mix		mcL	0.35
83	Coriell controls		mcL	29.41
84	Filtered, 1000mcL		item	1.18
85	Filtered, 10mcL		item	7.06
86	Filtered, 200mcL		item	7.06
87	Filtered, 20mcL		item	7.06
88	Formamide	SL192	mcL	1.00
89	gloves, non-sterile, nitrile	SB023	pair	0.50
90	gown, staff, impervious	SB027	item	0.38
91	High GC Buffer		mcL	4.71
92	Large volume compact		cartridge	
93	Map Marker		mcL	0.18
94	PCR 8 Tube Caps		item	2.35
95	PCR 8 Tube Strips, 0.2mL		item	2.35
96	Polymer for genetic analyzer		mcL	294.12
97	Strip caps		item	2.35
98	Strip tubes		item	2.35
99	SYBR Gel Stain		mcL	17.65
100	Triplet primed PCR enzyme mix		mcL	1.41
101				
102	**Equipment**			**Time in Use Minutes**
103	Analytical balance		EP004	1
104	Capillary electrophoresis instrument - fragment analysis			8
105	Centrifuge		EP059	1
106	Cooling block			1
107	Gel electrophoresis apparatus with power supply		EP063	4
108	Gel imaging system		EP062	1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81244**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 2*		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**80**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*62*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**69**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Confirm** orders	L033A	Lab Tech	1
13	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
14	Retrieve and accession specimen: Receiving sample, checking for unacdeptable conditions: clotted or frozen, serum, serverely hemolyzed samples, green top heparin (contains preservative that interfer with PCR)			
15	Gather all prior reports and history on the patient: enter reason for testing, gender of patient, family history of fragile X or autism-spectrum disease, etc.			
16	Check blood tube against requisition			
17	Log in patient with accession ID			
18	Print out labels			
19	Setup extraction labels			
20	**EXTRACTION and Reaction**	L045A	Cytotechnologist	4
21	Gather all needed cartriages, internal control, and elution tubes, reagents and racks. Inspect cartriage integrity and fill volume in wells.			
22	Label and Load 1.5ml sample tube and elution tube for Compact MagNAPure Compact			
23	Load onto Compact, set up Compact run conditions, and run			
24	Check DNA concentration and 260/280 ratio on NanoDrop			
25	Label patient tubes			
26	Dilute DNA			
27	Prepare restriction enzyme digestion reaction mix			
28	Aliquot restriction digestion reaction mix into each tube, add sample to the reaction mix			
29	Add diluted DNA			
30	Place in incubator			
31	**Gel**	L045A	Cytotechnologist	22
32	Prepare Gel			
33	Add Dye to samples			
34	Load gel			
35	Gel picture			
36	HCL			
37	NacL/NaOH			
38	NacL/Tris			
39	Prepare for blotting: Transfer DNA gel to Nytran membrane using turboblotter, wash membrane			
40	Blot the membrane dry and wrap in UV-transparent plastic wrap			
41	**Post Processing 1: PreHyb+Hyb**	L045A	Cytotechnologist	9
42	Prehyb			
43	Aliquot probe mix			
44	Put probe on ice			
45	Mix probe with hyb solution			
46	Add probe to blot + cap container			
47	**Post Processing 2: Stringency washes**	L045A	Cytotechnologist	5
48	Wash 1			
49	Wash 2			
50	**Post Processing 3: Detection**	L045A	Cytotechnologist	20
51	Wash 1			
52	Wash 2			
53	Prepare wash 3 (buffer + probe)			
54	Wash 3			
55	Wash 4			
56	Detection Buffer			
57	CPD			
58	Place film in cassette			
59	Expose Film			
60	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
61	**End: When specimen is ready for examination by physician**			
62	**Post-Service Period**			
63	**Start: When specimen examination by physician is complete**			
64	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
65	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
66	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
67	Clean Room	L033A	Lab Tech	2
68	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
69	Perform scheduled data management back-up	L033A	Lab Tech	1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81244**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 2*		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	
3		**CMS Code**	**Staff Type**	**Minutes**
70	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		**81244**	
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 2*		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	
3		**CMS Code**	**Staff Type**	**Minutes**
71	**SUPPLIES**		**Type of Unit**	**No. of Units**
72	DNA isolation		reaction	1
73	Bleach 10%	SL020	ml	0.75
74	Extraction tip assembly		each	1
75	Extraction tubs		each	4
76	Milli-Q water		ml	35
77	Masking tape		inches	12
78	1.5 mL tubes	SL240	tubes	5.88
79	AGAROSE		g	1.76
80	Anti-Dig Antibody		mcL	2.35
81	Blood collection (6mL, purple top)	SL242	unit	1.18
82	Blotting paper		sheet	1.18
83	Boric Acid		g	3.24
84	Bromophenol Blue		g	1.18
85	Chemiluminescent detection reagent		mL	1.18
86	Coriell controls		mcL	2.94
87	Dig Easy Hyb		mL	47.65
88	Digoxigenin Labeled Probe		mcL	11.76
89	DNA ladder, 100bp		mcL	23.53
90	Eag 1		mcL	0.12
91	EcoR1		mcL	0.59
92	EDTA		g	10.94
93	Ficoll		g	2.12
94	Film		film	1.18
95	Filtered, 1000mcL		tips	11.76
96	Filtered, 10mcL		tips	70.59
97	Filtered, 200mcL		tips	70.59
98	Filtered, 20mcL		tips	70.59
99	gloves, non-sterile	SB022	pair	1.00
100	gown, staff, impervious	SB027	item	0.75
101	HCL		mL	4.71
102	Large Volume Compact		cartrid	2.35
103	NaOH (Pellets), ACS	SL128	g	4.82
104	Nylon Membrane		sheet	1.18
105	Potassium Phosphate		g	0.48
106	Sheet protector		sheet	1.18
107	Sodium Chloride		g	142.99
108	Sodium Citrate	SL127	g	41.51
109	Sodium Dodecyl Sulfate		g	11.76
110	Sodium Phosphate		g	11.76
111	Spermidine		g	0.03
112	SYBR Gel Stain		mcL	17.65
113	Tris Base		g	20.60
114	Wash and Blocking Buffer Set		blot	1.18
115	Xylene Cyanol		g	1.18
116				
117	**Equipment**			**Time in Use Minutes**
118	37 degree incubator			600
119	Analytical balance		EP004	1
120	Gel electrophoresis apparatus with power supply		EP063	600
121	Gel imaging system		EP062	4
122	Micro-volume spectrophotometer with specimen retention technology			1
123	Nucleic acid extraction instrument			5

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81256**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 8*			*HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)*
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**28**
6	*Lab Tech*	*L033A*		*16*
7	*Cytotechnologist*	*L045A*		*12*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**19**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**9**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set Up**	L045A	Cytotechnologist	6
17	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
18	**End: When specimen is ready for examination by physician**			
19	**Service Period**			
20				
21	**Post-Service Period**			
22	**Start: When specimen examination by physician is complete**			
23	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
24	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
25	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
26	Clean Room	L033A	Lab Tech	1
27	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
28	Perform scheduled data management back-up	L033A	Lab Tech	1
29	**End: When specimen, chemical waste and record handling is complete**			
30	**SUPPLIES**		**Type of Unit**	**No. of Units**
31	DNA isolation kit		reaction	1
32	Gown	SB027	item	0.125
33	Bleach 10%	SL020	ml	0.375
34	PCR Water	SL244	ul	2
35	LightCycler 480 Genotyping Master Kit		Kit	1
36	LightCycler 480 Multiwell Plate 96		plate	2
37	Primers and Probes		ul	1
38	50 mL centrifuge tubes			2
39	Barrier pipet tips1000 uL		ul	2
40	Extraction tip assembly		each	1
41	Extraction tubs		each	4
42	2 plastic tubes (1 1.5mL/1 2.0mL)		item	5
43	20 µL barrier pipe tips		item	4
44	200 µL barrier pipet tips		item	4
45	25mL serological pipettes		item	2
46	5mL serological pipettes		item	3
47	Bench paper		meter	0.2187
48	Bouffant hats (pre and post)	SB001	item	0.25
49	DRF water	SL251	mL	3
50	drop catcher		item	1
51	gloves, nonsterile, nitrile	SB023	pairs	0.75
52	large reagent tubs/lids		item	2
53	medium reagent tubs/lids		item	4
54	Plastic bags (various sizes)		item	3
55	Plastic tubes		item	1
56	processing cartridges		item	2
57	sample cartridges		item	3
58	Shoe covers (pre and post)	SB039	pairs	0.25
59	Tip stand		item	1
60	High fidelity hot start Taq polymerase		ul	0.375

	A	B	C	D
61	Nucleic acid extraction instrument			5
62	Nucleic acid workstation			2
63	Pipet set		EP071	2
64	Real-time PCR instrument			6

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81270**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 5*			JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**37**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*19*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**26**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	Confirm orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set Up**	L045A	Cytotechnologist	13
17	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
18	**End: When specimen is ready for examination by physician**			
19	**Service Period**			
20				
21	**Post-Service Period**			
22	**Start: When specimen examination by physician is complete**			
23	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
24	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
25	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
26	Clean Room	L033A	Lab Tech	2
27	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
28	Perform scheduled data management back-up	L033A	Lab Tech	1
29	**End: When specimen, chemical waste and record handling is complete**			
30	**SUPPLIES**		**Type of Unit**	**No. of Units**
31	DNA isolation		reaction	1
32	Gown	SB027	item	0.4
33	Gloves, nonsterile	SB022	pair	1.2
34	Bleach 10%	SL020	ml	0.6
35	Extraction tip assembly		each	1
36	Extraction tubs		each	4
37	JAK2 MutaQuantTM Kit (24 reactions per kit in duplicate)		item	2
38	Lightcycler 96-well plates		item	1
39	LightCycler TaqMan Master Kit (480 reactions per kit)		item	2
40	PCR grade water	SL244	uL	2
41	V617F 25X probe mix		ul	0.8
42	V617F 50 copies standard		ul	10
43	V617F 500 copies standard		ul	10
44	V617F 5000 copies standard		ul	10
45	V617F 50000 copies standard		ul	10
46	V617F positive control		ul	10
47	WT 25X probe mix		ul	0.8
48	WT 50 copies standard		ul	10
49	WT 500 copies standard		ul	10
50	WT 5000 copies standard		ul	10
51	WT 50000 copies standard		ul	10
52	WT positive control		ul	10
53	15 mL centrifuge tubes	SL241		2
54	50 mL centrifuge tubes			2
55	Aerosol-resistant Pipette Tips, 0.1-20 ul		item	1
56	Aerosol-resistant Pipette Tips, 101-1000 ul		item	3
57	Aerosol-resistant Pipette Tips, 10-200 ul		item	12
58	Microcentrifuge Tubes, 0.5 ml		item	2
59	Barrier pipet tips 1000 uL		each	2
60	2 plastic tubes (1 1.5mL/1 2.0mL)		item	5
61	25mL serological pipettes		item	2
62	5mL serological pipettes		item	3
63	Bench paper		meter	1.5
64	Bouffant hats (pre and post)	SB001	item	0.4
65	DRF water	SL251	mL	3
66	drop catcher		item	1
67	large reagent tubs/lids		item	2

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81270**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 5*			JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant
3		**CMS Code**	**Staff Type**	**Minutes**
68	medium reagent tubs/lids		item	4
69	Plastic bags (various sizes)		item	3
70	processing cartridges		item	2
71	sample cartridges		item	3
72	Plastic tubes		item	1
73	Shoe covers (pre and post)	SB039	pairs	0.4
74	Tip stand		item	1
75	High fidelity hot start Taq polymerase		ul	0.375
76				
77	**Equipment**			**Time in Use Minutes**
78	Micro-volume spectrophotometer with specimen retention technology			1
79	Nucleic acid extraction instrument			5
80	Nucleic acid workstation			3
81	Pipet set		EP071	3
82	Real-time PCR instrument			9

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81275**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 5*			*KRAS gene analysis; variants in codons 12 and 13*
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**44**
6	*Lab Tech*	*L033A*	*Lab Tech*	*18*
7	*Cytotechnologist*	*L045A*	*Cytotechnologist*	*26*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**33**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	6
16	Cutting sections from specimen block using microtome			
17	Removal of paraffin			
18	DNA extraction			
19	Dilution of DNA extraction 1:5 or 1:10			
20	**PCR Reaction**	L045A	Cytotechnologist	18
21	Thaw the control reaction mix and mixed standard and mix			
22	Pipet mix control master mix			
23	Add mixed standard to tube A1, water tube A2, and sample to other tubes			
24	Close tubes and spin			
25	Place tubes into real-time PCR instrument			
26	Program instrument, enter run parameters, complete documentation			
27	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
28	**End: When specimen is ready for examination by physician**			
29	**Service Period**			
30				
31	**Post-Service Period**			
32	**Start: When specimen examination by physician is complete**			
33	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
34	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
35	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
36	Clean Room	L033A	Lab Tech	2
37	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
38	Perform scheduled data management back-up	L033A	Lab Tech	1
39	**End: When specimen, chemical waste and record handling is complete**			
40	**SUPPLIES**		**Type of Unit**	**No. of Units**
41	DNA isolation kit		kit	0.10
42	KRAS TheraScreen Mutation Kit		kit	0.25
43	Barrier pipet tips 20uL		each	8
44	100% ethanol	SL189	ml	50
45	8-well PCR tubes, clear, ultra thin		item	1
46	8-well StripCap, dome caps		item	1
47	95% Alcohol		ml	50
48	Biohazard bag with holder		item	1
49	Bleach, 10%	SL020	ml	4
50	Centrifuge tubes 15 mL	SL241	item	1
51	Centrifuge tubes 50 mL		item	1
52	DI water	SL244	ml	50
53	Ethanol, 70%	SL190	ml	10
54	EU thin wall plate 96 x 0.2 mL		item	1
55	EU wide optical 8-cap strip		item	1
56	Gauze, 4 x 4	SG051	item	1
57	Gloves,nonsterile,nitrile	SB023	item	2
58	gown, staff, impervious	SB027	item	1
59	Kimwipe	SM027	item	2
60	Micro tubes 2.0 mL		item	2
61	Micro tubes, 1.5 mL with caps		item	4
62	Microtube, 1.5 mL with locking lid		item	1
63	PCR Grade Water	SL244	ml	50
64	Pipette tips with aerosol barrier: 1000 µL		item	6
65	Pipette tips with aerosol barrier: 200 µL		item	6
66	Pipette tips with aerosol barrier: 100 µL		item	6
67	Pipette tips with aerosol barrier: 30 µL		item	6
68	Pipette tips with aerosol barrier: 10 uL		item	6
69	Xylene	SL151	ml	50

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81275**
2	**Meeting Date: April 2011** **Specialty: Pathology** *Adjusted for Batch Size - 5*			*KRAS gene analysis; variants in codons 12 and 13*
3		**CMS Code**	**Staff Type**	**Minutes**
70	Extraction tip assembly		each	1
71	Extraction tubs		each	1
72				
73	**Equipment**			**Time in Use Minutes**
74	Micro-volume spectrophotometer with specimen retention technology			1
75	Nucleic acid extraction instrument			5
76	Nucleic acid workstation			3
77	Pipet set		EP071	3
78	Real-time PCR instrument			9
79	Solvent recycler system			2
80				

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81291**
2	**Meeting Date: April 2011** *Adjusted for Batch Size - 4*			*MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)*
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**64**
6	*Lab Tech*	L033A		*18*
7	*Cytotechnologist*	L045A		*46*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**53**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	Confirm orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set Up**	L045A	Cytotechnologist	10
17	**PCR Gel**	L045A	Cytotechnologist	10
18	**PCR Post Processing**	L045A	Cytotechnologist	20
19	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
20	**End: When specimen is ready for examination by physician**			
21	**Service Period**			
22				
23	**Post-Service Period**			
24	**Start: When specimen examination by physician is complete**			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	**End: When specimen, chemical waste and record handling is complete**			
32	**SUPPLIES**		**Type of Unit**	**No. of Units**
33	DNA isolation kit		reaction	1
34	Gown	SB027	item	0.5
35	Gloves, nonsterile	SB022	pair	2.5
36	Bleach 10%	SL020	ml	0.75
37	High fidelity hot start Taq polymerase		ul	0.5
38	PCR buffer		ul	15
39	MgCl2		ul	4.5
40	F Primer		ul	3
41	R Primer		ul	3
42	dNTPs		ul	3
43	Restriction Enzyme: HinfI, 25000 Units restriction enzyme		ul	3
44	Restriction Enzyme: MboII, 1500 Units		ul	3
45	Agarose ultrapure		g	0.8
46	Agarose NuSieve GTG		g	1.6
47	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
48	0		ml	35
49	Masking tape		inches	12
50	DNA ladder, 100bp		ul	5
51	Loading buffer with dye	SL210	ul	20
52	BSA 100X		ul	3
53	PCR grade water	SL244	ul	102
54	0.2 mL PCR tubes		each	6
55	2 mL plastic tubes		each	2
56	Restriction enzyme buffer		ul	60
57	Milli-Q water		ml	35
58	Extraction tubs		each	4
59	15 mL centrifuge tubes	SL241		2
60	50 mL centrifuge tubes			2
61	Barrier pipet tips 200 uL		item	22
62	Barrier pipet tips 1000 uL		item	4
63	Barrier pipet tips 20 uL		item	55
64	0.5 mL tube		each	3
65	Extraction tip assembly		each	1
66				

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			**81291**
2	**Meeting Date: April 2011** *Adjusted for Batch Size - 4*			*MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)*
3		**CMS Code**	**Staff Type**	**Minutes**
67	**Equipment**			**Time in Use Minutes**
68	Analytical balance		EP004	1
69	Centrifuge		EP059	2
70	Cooling block			2
71	Gel electrophoresis apparatus with power supply		EP063	30

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			**81315**	**81316**
2	**Meeting Date: April 2011** *Typical Batch Size - 2*			*PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative*	*PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**93**	**93**
6	*Lab Tech*	*L033A*		*18*	*18*
7	*Cytotechnologist*	*L045A*		*75*	*75*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**82**	**82**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
11	**PRE-SERVICE**				
12	**Confirm** orders	L033A	Lab Tech	1	1
13	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
14	Clean counter top/new mat/obtain ice	L045A	Cytotechnologist	2	2
15	Label 5ml conical tube/pipette sample/ Add Buffer EL first wash	L045A	Cytotechnologist	2	2
16	Label kit tubes	L045A	Cytotechnologist	2	2
17	Remove supernatant/ Add Buffer EL second wash	L045A	Cytotechnologist	1	1
18	Remove supernatant/ place on ice/return to RNA bench	L045A	Cytotechnologist	2	2
19	Add RLT/BME/ pipette to mix/ pipette sample in QIAshredder	L045A	Cytotechnologist	1	1
20	Remove column/ Add ETOH to supernatant/ pipette to mix/Add half supernatant to QIAamp spin column	L045A	Cytotechnologist	1	1
21	Transfer QIAamp spin column to next collection tube/Add remainder of supernatant to column	L045A	Cytotechnologist	1	1
22	Transfer QIAamp spin column to next collection tube/Add RW1; Transfer QIAamp spin column to next collection tube/Add RPE; Transfer QIAamp spin column to next collection tube/Add RPE	L045A	Cytotechnologist	2	2
23	Transfer QIAamp column to 1.5 ml microcentrifuge tube/ Add Rnase-free water;Disgard QIAamp column/cap sample	L045A	Cytotechnologist	1	1
24	Initalize and blank nanodrop	L045A	Cytotechnologist	1	1
25	Quant sample/print	L045A	Cytotechnologist	1	1
26	Place sample in -70 freezer; Log quant information in RNA book	L045A	Cytotechnologist	1	1
27	Decontaminate environmental chambers and mark sheets (clean room and assembly area)	L045A	Cytotechnologist	1	1
28	Enter patient information onto cDNA and PCR worksheets; calculate assay set-up	L045A	Cytotechnologist	7	7
29	Clean counter top/new mat/obtain RNA free water from clean room; Obtain ice/controls and sample	L045A	Cytotechnologist	1	1
30	Label tubes/thaw samples/make sensitivity controls/pipette samples	L045A	Cytotechnologist	2	2
31	Heat RNA/obtain cDNA master mix reagents and thaw/make RT master mix	L045A	Cytotechnologist	2	2
32	Add RT master mix into samples/vortex	L045A	Cytotechnologist	3	3
33	Obtain PCR master mix reagents/go to clean room/label PCR tubes	L045A	Cytotechnologist	5	5
34	Thaw PCR master mix reagents/make master mixs for PMLRAR1, PMLRAR2, B2-microglobulin/vortex master mixs/quick centrifuge/aliquot into PCR strip tubes/cap/transfer to tamer 2	L045A	Cytotechnologist	5	5
35	Uncap PCR strip tubes/add samples to master mixs PMLRAR1, PMLRAR2, B2-microglobulin/cap samples	L045A	Cytotechnologist	2	2
36	Vortex PCR strip tubes/quick centrifuge/place samples in thermocycler	L045A	Cytotechnologist	1	1
37	Obtain samples from thermocycler/quick vortex/quick centrifuge/transfer to dark room	L045A	Cytotechnologist	1	1
38	Remove caps/load 6 ul loading dye to each PCR well leaving tip	L045A	Cytotechnologist	1	1
39	Fill bucket with water and place on hot plate	L045A	Cytotechnologist	1	1
40	Measure agarose on balance	L045A	Cytotechnologist	1	1
41	Add Tris to flask; Stir in agarose to bioling Tris	L045A	Cytotechnologist	1	1
42	Cool gel to room temperature and poor into gel apparatus	L045A	Cytotechnologist	1	1
43	Remove gel combs	L045A	Cytotechnologist	1	1
44	Add buffer	L045A	Cytotechnologist	1	1
45	Add loading dye to PCR strips	L045A	Cytotechnologist	2	2
46	Load DNA allelic ladder and PMLRAR1, PMLRAR2, and B2-microglobulin samples into gel/close gel box; Record sample location of all samples	L045A	Cytotechnologist	2	2
47	Obtain cords/hook up to electrophoresis power supply/set voltage and timer; Turn off power supply and unconnect power leads	L045A	Cytotechnologist	1	1
48	**GEL**	L045A	Cytotechnologist	13	13
49	Remove gels and place in tray				
50	Add stain (ethidium bromide); shake				
51	Remove ethidium bromide				
52	Place gel onto UV Transilluminator to check for band quality before analysis				
53	Place gels in buffer				
54	Turn on gel doc and open software; place gel into gel doc				
55	Capture image				
56	Label image with patient names, control information and primer sets				
57	Print image				
58	Clean gel doc				
59	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
60	**End: When specimen is ready for examination by physician**				
61	**Service Period**				
62					

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			**81315**	**81316**
2	**Meeting Date: April 2011** *Typical Batch Size - 2*			*PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative*	*PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative*
63	**Post-Service Period**				
64	**Start: When specimen examination by physician is complete**				
65	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
66	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
67	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
68	Clean Room	L033A	Lab Tech	2	2
69	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
70	Perform scheduled data management back-up	L033A	Lab Tech	1	1
71	**End: When specimen, chemical waste and record handling is complete**				
72	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
73	RNA isolation kit		Kit	0.04	0.04
74	PAXgene RNA tube		Kit	0.02	0.02
75	Gown	SB027	item	2	2
76	Gloves		pair	10	10
77	Bleach 10%	SL020	ml	30	30
78	PML-1 + RAR-1 primers - Intron 3 primers reconstituted in RNAse free water		ul	12	12
79	0.1ng/ul PML-1/RAR-1 Intron 3+ control		ul	1	1
80	1.5 microcentrifuge tube		item	1	1
81	1.5 ml microcentrifuge tubes		item	7	7
82	10 ml Serological pipette		item	1	1
83	10X TBE		ml	300	300
84	15 mL conical Tube		item	1	1
85	2 ml collection tube		item	4	4
86	3:1 agarose		grams	6.75	6.75
87	5 ml Serological pipette		item	2	2
88	50-1000 bp DNA marker		ul	60	60
89	8-strip 0.2 ml thin wall tubes		item	3	3
90	8-strip caps for 0.2 ml thin wall tubes		item	3	3
91	Aerosol resistant pipette tips – 0.2 - 10 ul		item	32	32
92	Aerosol resistant pipette tips – 1 - 1000 ul		item	7	7
93	Aerosol resistant pipette tips – 1 - 20 ul		item	28	28
94	Aerosol resistant pipette tips – 1 - 200 ul		item	40	40
95	Bench top mat		item	2	2
96	Beta 2 microglobulin primers reconstituted in RNAse free water		item	12	12
97	Biopolymer homogenizing kit		item	1	1
98	Deoxynucleotide Triphosphate Set, PCR Grade		ul	15	15
99	dNTP Mix, 5 mM each		ul	26	26
100	Face Shield		item	1	1
101	Glass Pasteur pipets		item	2	2
102	High fidelity hot start taq polymerase		ul	1.8	1.8
103	Human Universal Reference Total RNA control		ul	30	30
104	Labels for tubes		item	7	7
105	MgCl2		ul	18	18
106	Papertowels		item	6	6
107	PML/RARa t(15;17) L-form RNA IVS-0020 control		ul	2	2
108	PML-2 + RAR-2 primers - Intron 6 primers reconstituted in RNAse free water		ul	12	12
109	Random Primers		ul	7	7
110	Reverse transcriptase		ul	7	7
111	Reverse transcriptase buffer, 10X		ul	14	14
112	RNA extraction kit		item	0	0
113	RNase free water		ul	20	20
114	RNase-free water		ul	642	642
115	RNase-Inhibitor		ul	5.25	5.25
116	TE (Tris EDTA) Buffer 10:1 - 100X concentrate		ml	3000	3000
117	Test tube - purple top		item	1	1
118	Thin walled PCR tubes with caps		item	6	6
119	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
120	Analytical balance		EP004	1	1
121	Centrifuge		EP059	3	3
122	Cooling block			3	3
123	Gel electrophoresis apparatus with power supply		EP063	30	30
124	Gel imaging system		EP062	4	4
125	Micro-volume spectrophotometer with specimen retention technology			1	1
126	Nucleic acid extraction instrument			9	9
127	Nucleic acid workstation			15	15
128	Pipet set		EP071	20	20
129	Thermal cycler			50	50
130	Water bath		EP043	10	10

AMA/Specialty Society RVS Update Committee Summary of Recommendations

September 2011

Molecular Pathology-Tier 1

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010 and February 2011, the Panel accepted 92 Tier 1 codes, which are a list of gene-specific and genomic analysis CPT codes for high-volume molecular pathology services. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information, as a policy is developed to determine which payment schedule is appropriate for these services. In April 2011, the RUC recommended physician work and time values for 18 Tier I codes. In September 2011, the specialty presented data on the remaining 52 services. At this time, the specialty indicated that interpretation is not typically performed by a physician for the remaining Tier I codes.

81225 CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81225 was 13 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81225 is a more complex and intense service perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81225**.

81245 FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81245 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires

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more time than the surveyed code.. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81245**.

81350 UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81350 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physicianwork and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81350**.

81227 CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81227 was 14 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81227 is a more complex and intense service to perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.38, the survey's 25th percentile, for CPT code 81227**.

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81355 VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81355 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81355 is a more complex and intense service to perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.38, the survey's 25th percentile, for CPT code 81355**.

81310 NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants

The RUC reviewed the survey data as presented by the specialty society which indicated that the 75th percentile for time for 81310 was 19 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code.. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.39, the survey's 25th percentile, for CPT code 81310**.

81331 SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81331 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended

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at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.39, the survey's 25th percentile, for CPT code 81331**.

81265 Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81265 was 17 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is exactly the same as the surveyed code, however, 81265 overall is a more complex and intense service to perform. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.40, the survey's 25th percentile, for CPT code 81265**.

81266 Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81266 was 15 minutes. The RUC agreed that this time accurately reflects the amount of physician time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81266 is overall a more intense procedure to perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.41, the survey's 25th percentile, for CPT code 81266**.

81267 Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81267 was 18 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires

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more time than the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.45, the survey's 25th percentile, for CPT code 81267**.

81268 Chimerism (engraftment) analysis, post-transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81268 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar time to perform compared to the surveyed code, 81268. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.51, the survey's 25th percentile, for CPT code 81268**.

81226 CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81226 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time to perform compared to the surveyed code, 81226. The specialty society also explained, and the RUC agreed, that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.43, the survey's 25th percentile, for CPT code 81226**.

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81301 Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81301 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar physician time and intensity to perform compared to the surveyed code, 81301. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.50, the survey's 25th percentile, for CPT code 81301**.

81261 IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81261 was 21 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar physician time and intensity to perform compared to the surveyed code, 81261. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81261**.

81342 TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81342 was 25 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires less physician time and intensity to perform compared to the surveyed code, 81342. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the**

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RUC recommends a work RVU of 0.57, the survey's 25th percentile, for CPT code 81342.

81264 IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81264 was 22 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the key reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) requires less time compared to the surveyed code, 81264, the reference code is overall a more intense service to perform. The RUC also compared this service to 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site*, (Intra-time=20 minutes, Work RVU=0.60) which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.58, the survey's 25th percentile, for CPT code 81264**.

81262 IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81262 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the key reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) requires similar time compared to the surveyed code, 81262, the reference code is overall a more intense service to perform. The RUC also compared this service to 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site*, (Intra-time=20 minutes, Work RVU=0.60) which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.61, the survey's 25th percentile, for CPT code 81262**.

81210 BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81210 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time and intensity to perform compared to the surveyed code, 81210. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The

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specialty society also explained that this service keeps rank order with Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons),* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81210**.

81263 IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81263 was 23 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons),* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81263**.

81332 SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81332 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) is more than the surveyed code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.40, the survey's 25th percentile, for CPT code 81332**.

81257 HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time. The RUC agreed that 20 minutes accurately

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reflects the amount of time required to perform the service. The RUC also agreed with the specialty that the time associated with the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) is similar compared to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.50 for CPT code 81257**.

81340 TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81340 was 25 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared the surveyed code to 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (Intra-service time=20minutes, Work RVU=0.60) and noted that the surveyed code required more time to perform than the reference code. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.63, the survey's 25th percentile, for CPT code 81340.**

81293 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires much less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81293**.

81296 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
The specialty society explained that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work

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RVU=0.38), which requires much less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81296**.

81299 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81299**.

81303 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. However, the surveyed code requires less intensity to perform than the reference code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81303**.

81304 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81304**.

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81318 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81318.**

81300 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code 81300.**

81302 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code 81302.**

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81294 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81294.**

81297 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81297.**

81298 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81298.**

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81319 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81319.**

81292 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia,* which the RUC recommended at this meeting 1.40 work RVUs for 60 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this code to 96204 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires more work and time to perform. The RUC also compared the surveyed code to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Intra-service time=80minutes, work RVU=2.50) and acknowledged that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 1.40 for CPT code 81292.**

81295 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia,* which the RUC recommended at this meeting 1.40 work RVUs for 60 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this code to 96204 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires more work and time to perform. The RUC also compared the surveyed code to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Intra-service time=80minutes, work RVU=2.50) and acknowledged that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 1.40 for CPT code 81295.**

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81317 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia,* which the RUC recommended at this meeting 1.40 work RVUs for 60 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this code to 96204 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires more work and time to perform. The RUC also compared the surveyed code to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Intra-service time=80minutes, work RVU=2.50) and acknowledged that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 1.40 for CPT code 81317.**

81341 TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81341 was 19 minutes. The RUC agreed that this time accurately reflects the amount of physician time required to perform the service. The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45) The RUC agreed that this work RVU accurately reflected the amount of effort required to perform the service. The RUC compared this code to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (Intra-Service time=15 minutes, work RVU=0.38) and noted that the surveyed code requires more time and work to perform than the reference code. Further, the RUC compared the surveyed code to 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* (Intra-Service time=30 minutes, Work RVU=0.85) and noted that the surveyed code requires less work and time compared to this reference code. **Based on these comparisons, the RUC recommends 0.45 Work RVUs for 81341.**

81370 HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81370 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (total time = 20 minutes, work RVU = 0.60) is more than the surveyed code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although

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requires similar time to perform is overall a less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.54, the survey's 25th percentile, for CPT code 81370**.

81371 HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81371 was 30 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time=20 minutes, work RVU=0.52) is less than the surveyed code and that the reference code requires less intensity to perform. Further, the RUC also compared this service to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (intra-time=40 minutes, work RVU=0.94), which requires more work and time to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.60, the survey's 25th percentile, for CPT code 81371**.

81372 HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81372 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (total time=20 minutes, work RVU=0.60) is more than the surveyed code and that the reference code requires more intensity to perform. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although it requires similar time to perform, it is a less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81372**.

81373 HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81373 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is similar compared to the surveyed code and that the reference code requires similar intensity to perform compared to this reference code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which also requires similar time and intensity to perform compared to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81373**.

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81374 HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81374 was 13 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more compared to the surveyed code and that the reference code requires slightly more intensity to perform compared to this reference code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which also requires slightly more time to perform compared to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.34, the survey's 25th percentile, for CPT code 81374**.

81375 HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81375 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) is more than the surveyed code and that the reference code requires more intensity to perform. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although it requires similar time to perform the reference code is a less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.60, the survey's 25th percentile, for CPT code 81375**.

81376 HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81376 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) is more than the surveyed code.. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although it requires similar time to perform the reference code is less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.50, the survey's 25th percentile, for CPT code 81376**.

81377 HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81377 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for*

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diagnosis, first evaluation episode, each site (total time = 20 minutes, work RVU = 0.60) is more than the surveyed code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although requires similar time to perform it is a less intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.43, the survey's 25th percentile, for CPT code 81377**.

81378 HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81378 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar time compared to the surveyed code, 81378. However, this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81378**.

81379 HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81379 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81379**.

81380 HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each

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The RUC reviewed the survey data as presented by the specialty society which indicated that the median physician time for 81380 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code requires more intensity to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81380**.

81381 HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each
The specialty society recommended and the RUC agreed that the best way to evaluate this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (Intra-service=12minutes, work RVU=0.45) as these services require the same time and intensity to perform. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code, 81381 and this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81381**.

81382 HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3,-DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median physician time for 81382 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code, 81382 and this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is requires more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81382**.

81383 HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each

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The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81383 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code, 81383 and this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81383**.

Practice Expense

The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However the RUC agreed that the batch sizes should be re-examined when greater experience is available for these services. Further, The specialty society explained that the majority of these services are being crosswalked with minor differences to the practice expense inputs associated with the molecular pathology services that were approved at the April 2011 RUC Meeting. The remainder of the Molecular Pathology services, specifically, the HLA services, had new practice expense inputs. The PE Subcommittee reviewed all the recommended practice expense inputs over a conference call and during the PE Subcommittee meeting and made minor changes mostly pertaining to duplication in supplies and equipment, which were all subsequently approved by the RUC.

Work Neutrality

Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology

The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The physician time, work, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

Flagging in the RUC Database

The RUC recommends that all of the molecular pathology services with less than 30 survey responses should be flagged in the RUC database so that they are not used to validate the proposed work associated with any CPT codes under RUC review.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
Pathology and Laboratory **Molecular Pathology** **Tier 1 Molecular Pathology Procedures**					
Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (eg, constitutional disorders) or somatic (eg, neoplasia) conditions, or to test for histocompatibility antigens (eg, HLA). Code selection is typically based on the specific gene(s) that is being analyzed. Genes are described using Human Genome Organization (HUGO) approved gene names and are italicized in the code descriptors. Gene names were taken from tables of the HUGO Gene Nomenclature Committee (HGNC) at the time the CPT codes were developed. For the most part, Human Genome Variation Society (HGVS) recommendations were followed for the names of specific molecular variants. The familiar name is used for some variants because defined criteria were not in place when the variant was first described or because HGVS recommendations were changed over time (eg, intronic variants, processed proteins). When the gene name is represented by an abbreviation, the abbreviation is listed first, followed by the full gene name italicized in parentheses (eg, "F5 *[coagulation Factor V]*"), except for the HLA series of codes. Proteins or diseases commonly associated with the genes are listed as examples in the code descriptors. The examples do not represent all conditions in which testing of the gene may be indicated. Codes that describe tests to assess for the presence of gene variants (see definitions) use common gene variant names. Typically, all of the listed variants would be tested. However, these lists are not exclusive. If other variants are also tested in the analysis, they would be included in the procedure and not reported separately. Full gene sequencing should not be reported using codes that assess for the presence of gene variants unless specifically stated in the code descriptor. The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection). Any procedures required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately. The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection). Any procedures required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately. The results of the procedure may require interpretation by a physician. When only the interpretation and report are performed, modifier 26 may be appended to the specific molecular pathology code. All analyses are qualitative unless otherwise noted. For microbial identification, see 87149-87153 and 87470-87801, and 87900-87904. For in situ hybridization analyses, see 88271-88275 and 88365-88368.					

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
Molecular pathology procedures that are not specified in 81200-81350 should be reported using the appropriate methodology codes in the 83890-83914 and 88384-88386 series.					
●81200		ASPA (aspartoacylase) (eg, Canavan disease) gene analysis; common variants (eg, E285A, Y231X)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81205		BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis; common variants (eg, R183P, G278S, E422X)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81206	M1	BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	XXX	N/A	0.37 (RUC Recommended Value from April 2011 Meeting)
●81207	M2	minor breakpoint, qualitative or quantitative	XXX	N/A	0.15 (RUC Recommended Value from April 2011 Meeting)
●81208	M3	other breakpoint, qualitative or quantitative	XXX	N/A	0.46 (RUC Recommended Value from April 2011 Meeting)
●81209		BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis; (eg, 2281del6ins7)	XXX	N/A	Not Typically Performed by Physicians at this Time

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●81210	Z1	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	XXX	N/A	0.37
●81211		BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81212		185delAG, 5385insC, 6174delT variants	XXX	N/A	Not Typically Performed by Physicians at this Time
●81213		uncommon duplication/deletion variants	XXX	N/A	Not Typically Performed by Physicians at this Time
●81214		BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb) (When performing BRCA1 full sequence analysis with BRCA2 full sequence analysis use 81211)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81215		known familial variant	XXX	N/A	Not Typically Performed by Physicians at this Time
●81216		BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	XXX	N/A	Not Typically Performed by

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		(When performing BRCA2 full sequence analysis with BRCA1 full sequence analysis use 81211)			Physicians at this Time
●81217		known familial variant	XXX	N/A	Not Typically Performed by Physicians at this Time
●81220	M4	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines) (When Intron 8 poly-T analysis is performed in conjunction with CXXX1 in a R117H positive patient, do not report CXXX5)	XXX	N/A	0.15 (RUC Recommended Value from April 2011 Meeting)
●81221	M5	known familial variants	XXX	N/A	0.40 (RUC Recommended Value from April 2011 Meeting)
●81222	M6	duplication/deletion variants	XXX	N/A	0.22 (RUC Recommended Value from April 2011 Meeting)
●81223	M7	full gene sequence	XXX	N/A	0.40 (RUC Recommended

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
					Value from April 2011 Meeting)
●81224	M8	intron 8 poly-T analysis (eg, male infertility)	XXX	N/A	0.15 (RUC Recommended Value from April 2011 Meeting)
●81225	Z2	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	XXX	N/A	0.37
●81226	Z3	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	XXX	N/A	0.43
●81227	Z4	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	XXX	N/A	0.38
●81228		Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81229		interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (Do not report 81228 in conjunction with 81229)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81240	M9	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant	XXX	N/A	0.13 (RUC Recommended Value from April 2011

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
					Meeting)
●81241	M10	F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant	XXX	N/A	0.13 (RUC Recommended Value from April 2011 Meeting)
●81242		FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis; common variant (eg, IVS4+4A>T)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81243	M11	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles (For evaluation to detect and characterize abnormal alleles, see 81243, 81244) (For evaluation to detect and characterize abnormal alleles using a single assay [eg, PCR], use 81243)	XXX	N/A	0.37 (RUC Recommended Value from April 2011 Meeting)
●81244	M12	characterization of alleles (eg, expanded size and methylation status)	XXX	N/A	0.51 (RUC Recommended Value from April 2011 Meeting)
●81245	Z6	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	XXX	N/A	0.37

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●81250		G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis; common variants (eg, R83C, Q347X)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81251		GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis; common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81255		HEXA (hexosaminidase A (alpha polypeptide) (eg, Tay-Sachs disease) gene analysis; common variants (eg, 1278insTATC, 1421+1G>C, G269S)	XXX	N/A	Not Typically Performed by Physicians at this Time
●81256	M13	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)	XXX	N/A	0.13 (RUC Recommended Value from April 2011 Meeting)
●81257	Z7	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)	XXX	N/A	0.50
●81260		IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis; common variants (eg, 2507+6T>C, R696P)	XXX	N/A	Not Typically Performed by Physicians at this Time
● 81261	Z8	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	XXX	N/A	0.52
●81262	Z9	direct probe methodology (eg, Southern blot)	XXX	N/A	0.61

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●81263	Z10	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	XXX	N/A	0.52
●81264	Z11	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s) (For immunoglobulin lambda gene [IGL@] rearrangement or immunoglobulin kappa deleting element, [IGKDEL] analysis, report the appropriate methodology code[s] in the 83890-83914 series)	XXX	N/A	0.58
●81265	Z12	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	XXX	N/A	0.40
+●81266	Z13	each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure) (Use 81266 in conjunction with 81265)	ZZZ	N/A	0.41
●81267	Z14	Chimerism (engraftment) analysis, post ~~hematopoietic stem cell~~ transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	XXX	N/A	0.45
●81268	Z15	with cell selection (eg, CD3, CD33), each cell type (If comparative ~~baseline~~ STR analysis of recipient [using buccal swab or other germline tissue sample] and donor are performed after hematopoietic stem cell transplantation, report IXXX6-	XXX	N/A	0.51

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		IXXX7 in conjunction with IXXX8-IXXX9 for chimerism testing)			
●81270	M14	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant	XXX	N/A	0.15 (RUC Recommended Value from April 2011 Meeting)
●81275	M15	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis; variants in codons 12 and 13	XXX	N/A	0.50 (RUC Recommended Value from April 2011 Meeting)
●81280		Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); full sequence analysis	XXX	N/A	Not Typically Performed by Physicians at this Time
●81281		known familial sequence variant	XXX	N/A	Not Typically Performed by Physicians at this Time
●81282		duplication/deletion variants	XXX	N/A	Not Typically Performed by Physicians at this Time
●81290		MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis; common variants (eg, IVS3-2A>G, del6.4kb)	XXX	N/A	Not Typically Performed by Physicians at this Time

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●81291	M16	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)	XXX	N/A	0.15 (RUC Recommended Value from April 2011 Meeting)
●81292	Z16	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	N/A	1.40
●81293	Z17	known familial variants	XXX	N/A	0.52
●81294	Z18	duplication/deletion variants	XXX	N/A	0.80
●81295	Z19	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	N/A	1.40
●81296	Z20	known familial variants	XXX	N/A	0.52
●81297	Z21	duplication/deletion variants	XXX	N/A	0.80
●81298	Z22	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	N/A	0.80
●81299	Z23	known familial variants	XXX	N/A	0.52
●81300	Z24	duplication/deletion variants	XXX	N/A	0.65
●81301	Z25	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	XXX	N/A	0.50
●81302	Z26	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	XXX	N/A	0.65

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
• 81303	Z27	known familial variant	XXX	N/A	0.52
•81304	Z28	duplication/deletion variants	XXX	N/A	0.52
•81310	Z29	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	XXX	N/A	0.39
•81315	M17	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha ~~PML-RARA regulated adaptor molecule 1~~) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	XXX	N/A	0.37 (RUC Recommended Value from April 2011 Meeting)
•81316	M18	single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative (For intron 3 and intron 6 [including exon 6 if performed] analysis, use 81315) (If both intron 6 and exon 6 are analyzed, without intron 3, use one unit of 81316)	XXX	N/A	0.22 (RUC Recommended Value from April 2011 Meeting)
•81317	Z30	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	N/A	1.40
•81318	Z31	known familial variants	XXX	N/A	0.52
•81319	Z32	duplication/deletion variants	XXX	N/A	0.80
•81330		SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis; common variants (eg, R496L, L302P, fsP330)	XXX	N/A	Not Typically Performed by Physicians at this Time
•81331	Z33	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome	XXX	N/A	0.39

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		and/or Angelman syndrome), methylation analysis			
●81332	Z34	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	XXX	N/A	0.40
●81340	Z35	TRB@~~TCB@~~ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	XXX	N/A	0.63
●81341	Z36	using direct probe methodology (eg, Southern blot)	XXX	N/A	0.45
●81342	Z37	TRG@ ~~TCG@~~ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s) (For T cell antigen alpha [TRA@ ~~TCA@~~] gene rearrangement analysis, report the appropriate methodology code(s) in the 83890-83914 series) (For T cell antigen delta [TCD@] gene rearrangement analysis, report 81341)	XXX	N/A	0.57
●81350	Z38	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	XXX	N/A	0.37

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●81355	Z5	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	XXX	N/A	0.38
Human Leukocyte Antigen (HLA) typing is performed to assess compatibility of recipients and potential donors as a part of solid organ and hematopoietic stem cell pretransplant testing. HLA testing is also performed to identify HLA alleles and allele groups (antigen equivalents) associated with specific diseases and individualized responses to drug therapy (eg, HLA-B*27 and ankylosing spondylitis and HLA-B*57:01 and abacavir hypersensitivity), as well as other clinical uses. One or more HLA genes may be tested in specific clinical situations (eg, HLA-DQB1 for narcolepsy and HLA-A, -B, -C, -DRB1 and -DQB1 for kidney transplantation). Each HLA gene typically has multiple variant alleles or alleles groups that can be identified by typing. For HLA result reporting, a low resolution HLA type is denoted by a two digit HLA name (eg, A*02) and intermediate resolution typing by a string of alleles or an NMDP (National Marrow Donor Program) code (eg, B*14:01/07N/08/12/14, B*39CKGN). Both low and intermediate resolution, both of which are considered low resolution for code assignment. and hHigh resolution typing resolves the common well defined (CWD) alleles and is usually denoted by a greaterat least 4 number of digits (eg, A*02:02, *03:01:01:01, A*26:01:01G, and C*03:04P), however, high resolution typing may include some ambiguities for rare alleles, which may be reported as a string of alleles or an NMDP code. If additional testing is required to resolve ambiguous allele combinations for high resolution typing, it this is included in the base HLA typing codes below. The gene names have been italicized similar to the other molecular pathology codes.					
●81370	Z39	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	XXX	N/A	0.54
●81371	Z40	HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	XXX	N/A	0.60
●81372	Z41	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C) (When performing both Class I and II low resolution HLA typing for HLA-A,-B,-C, -DRB1/3/4/5, and -DQB1, use 81370)	XXX	N/A	0.52
●81373	Z42	one locus (eg, HLA-A, -B, or -C), each (When performing a complete Class I [HLA-A,-B, and -C] low resolution HLA typing, use 81372) (When the presence or absence of a single antigen equivalent is reported using low resolution testing, use 81374)	XXX	N/A	0.37

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
•81374	Z43	one antigen equivalent (eg, B*27), each (When testing for presence or absence of more than 2 antigen equivalents at a locus, use HLXX4 for each locus tested)	XXX	N/A	0.34
•81375	Z44	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1 (When performing both Class I and II low resolution HLA typing for HLA-A,-B,-C, -DRB1/3/4/5, and –DQB1, use 81370)	XXX	N/A	0.60
•81376	Z45	one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each (When low resolution typing is performed for HLA-DRB1/3/4/5 and -DQB1, use HLXX6) (For low resolution typing, HLA-DRB1/3/4/5 should be treated as a single locus)	XXX	N/A	0.50
•81377	Z46	one antigen equivalent, each (When testing for presence or absence of more than 2 antigen equivalents at a locus, use 81379 for each locus)	XXX	N/A	0.43
•81378	Z47	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	XXX	N/A	0.45
•81379	Z48	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	XXX	N/A	0.45
•81380	Z49	one locus (eg, HLA-A, -B, or -C), each	XXX	N/A	0.45

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		(When a complete Class I high resolution typing for HLA-A,-B, and -C is performed, use 81379) (When the presence or absence of a single allele or allele group is reported using high resolution testing, use 81381)			
●81381	Z50	one allele or allele group (eg, B*57:01P), each (When testing for the presence or absence of more than 2 alleles or allele groups at a locus, use 81380 for each locus)	XXX	N/A	0.45
●81382	Z51	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3,-DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each (When only the presence or absence of a single allele or allele group is reported using high resolution testing, use 81383)	XXX	N/A	0.45
●81383	Z52	one allele or allele group (eg, HLA-DQB1*06:02P), each (When testing for the presence or absence of more than 2 alleles or allele groups at a locus, use 81382 for each locus)	XXX	N/A	0.45
83912		Molecular diagnostics; interpretation and report	XXX	N/A	0.37 (No Change)
E 86822		HLA typing; lymphocyte culture, primed (PLC) (For HLA typing by molecular pathology techniques, see 81370-8138~~3890-83914 with appropriate genetic testing~~	XXX	Paid on the Clinical Lab Fee Schedule	Paid on Clinical Lab Fee Schedule

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CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		~~modifiers 4A-4G~~)			

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Molecular Pathology-Tier 1
TAB 5 - HLA Codes

CPT	Track	Resp	Long Descriptor	RVU Recommendation Original	RVU Recommendation Post Pre-Facilitation	Total Time	IWPUT	Rationale	
81370	Z39	30	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	0.54	0.54	15	0.036	Greater than 10 SNPs	81402
81371	Z40	15	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	0.77	0.60	30	0.026	Greater than 10 SNPs	81402
81372	Z41	15	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	0.52	0.52	15	0.035	Greater than 10 SNPs	81402
81373	Z42	15	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, B, or -C), each	0.37	0.37	15	0.025	Greater than 10 SNPs	81402
81374	Z43	10	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	0.34	0.34	13	0.026	2-10 SNPs	81402
81375	Z44	11	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	0.60	0.60	15	0.040	Greater than 10 SNPs	81402
81376	Z45	12	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	0.62	0.50	15	0.033	Greater than 10 SNPs	81402
81377	Z46	9	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	0.43	0.43	15	0.029	Greater than 10 SNPs	
81378	Z47	17	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	0.45	0.45	20	0.023	16 exons	
81379	Z48	9	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	0.45	0.45	15	0.030		
81380	Z49	9	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	0.45	0.45	15	0.030		
81381	Z50	11	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	0.45	0.45	12	0.038		
81382	Z51	10	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each	0.45	0.45	15	0.030		
81383	Z52	11	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	0.45	0.45	15	0.030	Greater than 10 SNPs crosswalked below 25th percentile based on time	81402

Molecular Pathology-Tier 1
TAB 5 - Codes Valued by Survey - Validation by Crosswalk

CPT	Track	Resp	Long Descriptor	RVU Recommendation Original	RVU Recommendation Post Pre-Facilitation	Total Time	IWPUT	Rationale
81401			**Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)CCND1/ IGH (BCL1/ IGH, t[(11;14]d) (eg,**					
81225	Z2	16	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	0.37	0.37	13	0.028	PCR of 2 to 10 varients
81245	Z6	44	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	0.37	0.37	15	0.025	1 Somatic Varient
81350	Z38	10	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	0.37	0.37	15	0.025	2-10 varients
81227	Z4	12	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	0.38	0.38	14	0.027	PCR with 2 to 10 varients
81355	Z5	12	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	0.38	0.38	15	0.025	PCR with 2 to 10 varients
81310	Z29	26	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	0.39	0.39	19	0.021	One somatic varient, non sequencing
81331	Z33	11	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	0.39	0.39	15	0.026	Detection of a methylated variant
81265	Z12	37	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample]	0.40	0.40	17	0.024	Detection of a dynamic mutation disorder/triplet repeat
81266	Z13	12	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition	0.41	0.41	15	0.027	Detection of a dynamic mutation disorder/triplet repeat
81267	Z14	27	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection	0.52	0.45	18	0.025	Detection of a dynamic mutation disorder/triplet repeat
81268	Z15	23	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type (If comparative STR analysis of recipient [using	0.75	0.51	20	0.026	Detection of a dynamic mutation disorder/triplet repeat

Molecular Pathology-Tier 1
TAB 5 - Codes Valued by Survey - Validation by Crosswalk

CPT	Track	Resp	Long Descriptor	RVU Recommendation		Total Time	IWPUT	Rationale
				Original	Post Pre-Facilitation			
81402	**Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon**							
81226	Z3	8	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	0.43	0.43	15	0.029	PCR greater than 10 varients
81301	Z25	41	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	0.50	0.50	20	0.025	Dynamic mutation disorder, two specimens
81261	Z8	58	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas) gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	0.52	0.52	21	0.025	Immunoglobulin and T cell receptor gene rearrangements
81342	Z37	50	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.57	0.57	25	0.023	T-cell gene rearrangement
81264	Z11	23	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.75	0.58	22	0.026	Immunoglobulin and T cell receptor gene rearrangements
81262	Z9	13	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas) gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	0.61	0.61	20	0.031	Immunoglobulin and T cell receptor gene rearrangements
81403	**Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)**							
81210	Z1	66	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	0.37	0.37	15	0.025	one exon sequencing
81263	Z10	10	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma) variable region somatic mutation analysis	0.74	0.52	23	0.023	Analysis of single exon by DNA sequence analysis

Molecular Pathology-Tier 1
TAB 5 - Codes Crosswalked Value to Tier 2

CPT	Track	Resp	Long Descriptor	RVU Recommendation Original	RVU Recommendation Post Pre-Facilitation	Total Time	IWPUT	Rationale
81401			**Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)CCND1/ IGH (BCL1/ IGH, t[(11;14]d) (eg,**					
81332	Z34	3	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	0.40	0.40	15	0.027	2-10 SNPs
81402			**Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon**					
81257	Z7	5	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart's hydrops fetalis syndrome, HbH disease), gene analysis; for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and	0.50	0.50	20	0.025	Duplication/deletion varients
81340	Z35	28	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	0.63	0.63	25	0.025	T-cell gene rearrangements
81403			**Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)**					
81293	Z17	4	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.52	0.52	28	0.019	Single exon
81296	Z20	3	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.52	0.52	28	0.019	Sequencing single exon
81299	Z23	2	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.52	0.52	28	0.019	Sequencing single exon
81303	Z27	1	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	0.52	0.52	28	0.019	Single exon by sequence analysis
81304	Z28	1	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	0.52	0.52	28	0.019	Duplication/deletion variants of 2-5 exons
81318	Z31	1	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.52	0.52	28	0.019	Single exon sequencing

Molecular Pathology-Tier 1
TAB 5 - Codes Crosswalked Value to Tier 2

CPT	Track	Resp	Long Descriptor	RVU Recommendation Original	RVU Recommendation Post Pre-Facilitation	Total Time	IWPUT	Rationale
81404	**Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)**							
81300	Z24	3	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.65	0.65	30	0.022	Duplication/deletion variants of 6-10 exons
81302	Z26	4	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	0.65	0.65	30	0.022	2-5 exons by sequence analysis
81405	**Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)**							
81294	Z18	3	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.80	0.80	30	0.027	Sequencing 6-10 exons
81297	Z21	3	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non- polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.80	0.80	30	0.027	Duplication/deletion variants of 11-25 exons
81298	Z22	3	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.80	0.80	30	0.027	Sequencing 6-10 exons
81319	Z32	1	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.80	0.80	30	0.027	Duplication/deletion variants of 11-25 exons
81406	**Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)**							
81292	Z16	4	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	1.40	1.40	60	0.023	11 to 25 exons
81295	Z19	2	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	1.40	1.40	60	0.023	Duplication/deletion variants
81317	Z30	1	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	1.40	1.40	60	0.023	11-25 exons DNA sequencing
88388	**Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)**							
81341	Z36	8	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	0.45	0.45	19	0.024	T-cell gene rearrangement

Molecular Pathology-Tier 2
TAB 6

Source	CPT	Track	Resp	Long Descriptor	IWPUT	Survey RVW					Total	Survey Intra-Service Time				
						Low	25th	Median	75th	High	Time	Low	25th	Median	75th	High
REF	86320			Immunoelectrophoresis; serum	0.019			0.37			20			20		
SVY	81400	AA1	94	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)	0.037	0.13	0.32	0.37	0.52	1.83	10	3	7	10	20	30
REC	81400	AA1			0.032			0.32			10			10		
REF	88291			Cytogenetics and molecular cytogenetics, interpretation and report	0.026			0.52			20			20		
SVY	81401	AA2	59	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)CCND1/ IGH (BCL1/ IGH, t[(11;14]d) (eg,	0.033	0.25	0.40	0.50	0.68	1.90	15	5	10	15	22	60
REC	81401	AA2			0.027			0.40			15			15		
REF	88291			Cytogenetics and molecular cytogenetics, interpretation and report	0.026			0.52			20			20		
SVY	81402	AA3	61	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon	0.026	0.25	0.50	0.52	0.87	2.50	20	5	15	20	30	50
REC	81402	AA3			0.025			0.50			20			20		
REF	88291			Cytogenetics and molecular cytogenetics, interpretation and report	0.026			0.52			20			20		
SVY	81403	AA4	47	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	0.028	0.40	0.52	0.77	1.00	2.50	28	10	20	28	35	60
REC	81403	AA4			0.019			0.52			28			28		
REF	88291			Level VI - Surgical pathology, gross and microscopic examination	0.026			0.52			20			20		
SVY	81404	AA5	49	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	0.028	0.50	0.65	0.83	1.15	2.80	30	7	20	30	45	60
REC	81404	AA5			0.022			0.65			30			30		

Molecular Pathology-Tier 2
TAB 6

Source	CPT	Track	Resp	Long Descriptor	IWPUT	Survey RVW					Total	Survey Intra-Service Time				
						Low	25th	Median	75th	High	Time	Low	25th	Median	75th	High
REF	88112			Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	0.027			1.18			43			43		
SVY	81405	AA6	31	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)	0.031	0.52	0.80	0.94	1.40	4.50	30	10	20	30	60	80
REC	81405	AA6			0.027			0.80			30			30		
REF	88323			Consultation and report on referred material requiring preparation of slides	0.033			1.83			56			56		
SVY	81406	AA7	27	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	0.023	0.70	1.00	1.40	1.84	2.80	60	15	38	60	83	120
REC	81406	AA7			0.023			1.40			60			60		
REF	88309			Level VI - Surgical pathology, gross and microscopic examination	0.031			2.80			90			90		
SVY	81407	AA8	15	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)	0.031	1.00	1.20	1.85	2.80	5.00	60	20	30	60	100	180
REC	81407	AA8			0.031			1.85			60			60		
REF	88309			Level VI - Surgical pathology, gross and microscopic examination	0.031			2.80			90			90		
SVY	81408	AA9	15	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)	0.035	1.30	2.35	2.80	2.85	3.50	80	18	45	80	150	215
REC	81408	AA9			0.029			2.35			80			80		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81210 Tracking Number Z1 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old man with metastatic colorectal carcinoma is being considered for targeted therapy with anti-epidermal growth factor receptor (EGFR) monoclonal antibodies. Initial molecular studies indicate the tumor does not contain any of 12 common KRAS mutations at codons 12 or 13. A tumor-rich tissue sample is submitted for BRAF gene mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: Paraffin is removed, and high quality DNA is isolated from the patient's tumor tissue. DNA is subjected to PCR amplification for exon 15 of the BRAF gene. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing on a capillary electrophoresis instrument. The pathologist evaluates the electropherograms to identify nucleotide sequence variants. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81210		
Sample Size:	875	**Resp N:** 66	**Response:** 7.5 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	20.00	**50.00**	100.00	800.00
Survey RVW:	0.15	0.37	**0.52**	0.77	1.83
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81210	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
96446	XXX	0.37	**RUC Time**

CPT Descriptor Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 28.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 81210**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.26	3.32
Urgency of medical decision making	3.53	3.53
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.79	3.89
Physical effort required	2.63	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.21	3.37
Outcome depends on the skill and judgment of physician	3.47	3.63
Estimated risk of malpractice suit with poor outcome	3.21	3.32

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.26	3.58
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from 66 pathologists and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81210 is slightly less intense

and complex as 88291, although the median Work RVU = 0.52. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.37 appropriately values new CPT code 81210 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81225 Tracking Number Z2 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year-old Caucasian man is seen by a cardiologist after experiencing an acute myocardial infarct. The physician is considering percutaneous coronary intervention for this patient and needs to place the patient on an anti-platelet drug (clopidogrel) to prevent clotting. To determine whether the standard 300 mg loading dose of clopidogrel should be altered, a sample of anticoagulated peripheral blood is submitted to the laboratory to test for common variants in the CYP2C19 gene.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to two amplification reactions (PCR). Pooled PCR amplicons are enzymatically fragmented, labeled with biotin, and hybridized to a microarray containing oligonucleotide probes. After staining with a streptavidin-conjugated fluorescent dye, the array is scanned to detect signal from the hybridized DNA fragments. The pathologist evaluates the allelic ratios and data supporting the recommended identification of specific CYP2C19 variants. The pathologist composes a report which specifies the patient's CYP2C19 allele status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81225					
Sample Size:	875	**Resp N:**	16	**Response:** 1.8 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	19.00	**23.00**	50.00	120.00
Survey RVW:	0.16	0.37	**0.50**	0.73	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**13.00**	21.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81225	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**13.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
96446	XXX	0.37	**RUC Time**

CPT Descriptor Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 31.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 81225**	**Key Reference CPT Code:** 86320	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	13.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**13.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.40
Urgency of medical decision making	3.80	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.40	3.60
Physical effort required	2.00	2.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.60	3.20
Outcome depends on the skill and judgment of physician	3.00	3.20
Estimated risk of malpractice suit with poor outcome	3.60	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.20	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 886320 (Work RVU = 0.37, 17 minutes). The survey respondents indicated code 81225 is

more intense and complex than 86320 with a median Work RVU = 0.50. The expert panel agreed that the median physician time of 13 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.37 appropriately values new CPT code 81225 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81226 Tracking Number Z3 Original Specialty Recommended RVU: **0.43**
Presented Recommended RVU: **0.43**
Global Period: XXX RUC Recommended RVU: **0.43**

CPT Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A pre-menopausal 47-year-old woman is seen by an oncologist for breast cancer. Her tumor was positive for estrogen and progesterone receptors. The oncologist is considering treatment with tamoxifen rather than an aromatase inhibitor. To aid in this decision, the oncologist desires to predict the patient's ability to metabolize tamoxifen to the more active drug, endoxifen. A sample of anticoagulated peripheral blood is submitted to the laboratory to test for common variants in the CYP2D6 gene.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to two amplification reactions (PCR). Pooled PCR amplicons are enzymatically fragmented, labeled with biotin, and hybridized to a microarray containing oligonucleotide probes. After staining with a streptavidin-conjugated fluorescent dye, the array is scanned to detect signal from the hybridized DNA fragments. The pathologist evaluates the allelic ratios and data supporting the recommended identification of specific CYP2D6 variants. The pathologist composes a report which specifies the patient's CYP2D6 allele status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81226				
Sample Size:	875	**Resp N:**	8	**Response:** 0.9 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**10.00**	12.00	50.00
Survey RVW:	0.37	0.43	**0.50**	0.50	0.52
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	14.00	**15.00**	15.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81226	**Recommended Physician Work RVU: 0.43**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,186,775

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
93923	XXX	0.45	**RUC Time**

CPT Descriptor Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 42.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 81226**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.33
Urgency of medical decision making	4.00	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	3.67
Physical effort required	3.67	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.33
Outcome depends on the skill and judgment of physician	3.67	3.33
Estimated risk of malpractice suit with poor outcome	3.67	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.33
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81226 is more intense and complex than 88291, although the median Work RVU = 0.50. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.43 appropriately values new CPT code 81226 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81227 Tracking Number Z4 Original Specialty Recommended RVU: **0.38**
Presented Recommended RVU: **0.38**
Global Period: XXX RUC Recommended RVU: **0.38**

CPT Descriptor: CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents to his physician with complaints of fatigue, lightheadedness, and palpitations. Diagnostic workup revealed atrial fibrillation, for which the physician would like to prescribe warfarin. In order to facilitate rapid achievement of the proper dose, she orders warfarin sensitivity genotyping for common variants of the CYP2C9 gene, which have been shown to significantly influence the dose of warfarin needed to achieve appropriate therapeutic levels. A sample of peripheral blood is submitted to the laboratory for genotypic analysis of the CYP2C9 gene.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to a multiplexed PCR reaction, using primers specific for the most common variants, CYP2C9(*2) and CYP2C9(*3). The amplified target DNA is hybridized to a ferrocene signal probe and to an allele-specific capture probe, which is immobilized on an oligoarray. The captured target DNA generates a specific electrochemical signal that identifies the target DNA sequence. The pathologist examines the data and analytic system controls, and determines whether CYP2C9 variants are present in the patient's sample. The pathologist composes a report which specifies the patient's genotype. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81227		
Sample Size:	875	**Resp N:** 12	**Response:** 1.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	18.00	20.00	**20.00**	56.00	100.00
Survey RVW:	0.32	0.38	**0.50**	0.71	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	10.00	**14.00**	19.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81227	**Recommended Physician Work RVU: 0.38**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**14.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
93790	XXX	0.38	**RUC Time**

CPT Descriptor Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81227**	**Key Reference CPT Code:** 86320	**Source of Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	14.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**14.00**	**17.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.67	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.17
Urgency of medical decision making	3.50	2.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.83	3.17
Physical effort required	2.33	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.33	3.00
Outcome depends on the skill and judgment of physician	3.17	3.33
Estimated risk of malpractice suit with poor outcome	3.17	2.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	2.83
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 86320 (Work RVU = 0.37, 17 minutes). The survey respondents indicated code 81227 is more intense and complex as 86320 and the median Work RVU = 0.50. The expert panel agreed that the median physician time of 14 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.38 appropriately values new CPT code 81227 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. `

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81245 Tracking Number Z6 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old man presents to his primary care physician complaining of fatigue, dyspnea on exertion, and easy bruising. The patient's hemogram demonstrates leukocytosis with 30% blasts, anemia and thrombocytopenia. The peripheral blood smear shows decreased platelets and red blood cells along with large blasts with prominent nucleoli and Auer rods. The bone marrow contains 80% blasts which demonstrate an aberrant immunophenotype (CD33/CD13-positive with some cells expressing CD34 and CD117). The karyotype of the malignant cells is normal. An anticoagulated bone marrow specimen is submitted to the laboratory for FLT3 internal tandem duplication (ITD) mutation analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from the bone marrow sample and subjected to a single PCR amplification encompassing the region which normally contains FLT3 internal tandem duplications. The fluorescent PCR products are separated by capillary electrophoresis. The pathologist evaluates the electropherogram comparing the relative sizes of the PCR product(s) to a control peak to determine FLT3/ITD mutation status. The pathologist composes a report which specifies the FLT3 ITD mutation status of the patient's leukemic cells. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81245		
Sample Size:	875	**Resp N:** 44	**Response:** 5.0 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	20.00	**35.00**	80.00	150.00
Survey RVW:	0.13	0.37	**0.45**	0.52	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81245	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
96446	XXX	0.37	**RUC Time**

CPT Descriptor Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 31.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 81245**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.14	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.57
Urgency of medical decision making	3.43	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.93
Physical effort required	2.37	3.21
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.29
Outcome depends on the skill and judgment of physician	3.36	3.71
Estimated risk of malpractice suit with poor outcome	3.29	3.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.21	3.43
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from 44 pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81245 is less intense and

complex as 88291, and theWork RVU = 0.45. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.37 appropriately values new CPT code 81245 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81257 Tracking Number Z7 Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart's hydrops fetalis syndrome, HbH disease), gene analysis; for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26-year-old G1P0 woman of Vietnamese descent presents to her obstetrician for a first prenatal visit after missing a menstrual cycle and obtaining a positive home pregnancy test result. Both the patient and her partner have been identified as alpha thalassemia carriers by hemoglobin electrophoresis. An anticoagulated peripheral blood sample is submitted to the laboratory for testing to identify the specific type of alpha thalassemia mutation the patient carries.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to multiplex PCR amplification utilizing primers for 7 commonly occurring alpha thalassemia deletions. The PCR products, a molecular weight marker, and an allelic ladder are separated by gel electrophoresis. The pathologist evaluates the patterns of the PCR products on the gel in order to identify the patient's specific deletion. The pathologist composes a report specifying the patient's mutation status and the respective chromosomal locations (eg cis, trans). The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81257		
Sample Size:	875	**Resp N:** 5	**Response:** 0.5 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	10.00	**25.00**	400.00	716.00
Survey RVW:	0.30	0.50	**0.52**	0.52	0.65
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	5.00	**15.00**	15.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81257	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
99407	XXX	0.50	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 60.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81257**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.67
Urgency of medical decision making	3.33	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.67
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.33
Outcome depends on the skill and judgment of physician	3.33	3.33
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.67	3.67
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81257 with that of new tier 2 service 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)* (Recommended Work RVU = 0.50, 20 minutes). CAP recommends a direct crosswalk of 81257 to the physician work and time of CPT code 81402, based on work described in the CPT descriptors. A physician Work RVU of 0.50 also represents the 25th percentile of the survey respondents.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81261 Tracking Number Z8 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas) gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An enlarged supraclavicular lymph node is identified during physical examination of 62-year-old man at a routine physician visit. A biopsy of the supraclavicular node is taken; initial morphologic and immunologic studies demonstrate a B-cell population that is suspicious for malignancy. A lymph node sample is submitted for immunoglobulin heavy chain gene rearrangement analysis for further evidence of a clonal B-lymphoid population.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from the lymph node sample and subjected to five multiplex PCR amplification reactions using fluorescently-tagged primers directed at various framework, diversity and joining regions of the immunoglobulin heavy chain gene. Following amplification, the reaction products from each tube are separately subjected to capillary electrophoresis. The pathologist evaluates the electrophoretic tracings for one or two predominant fragments of discrete size against background polyclonal or oligoclonal peaks for evidence of clonality. The pathologist composes a report which specifies the clonality status of the B-cell population in the patient sample. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81261		
Sample Size:	875	**Resp N:** 58	**Response:** 6.6 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	35.00	**50.00**	126.00	500.00
Survey RVW:	0.35	0.52	**0.77**	0.93	2.20
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	15.00	**21.00**	30.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81261	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**21.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service?

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 2 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 25.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 81261**	**Key Reference CPT Code:** 88291	**Source of Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	21.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**21.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.13
Urgency of medical decision making	3.93	3.87
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.13
Physical effort required	3.27	3.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.93	3.87
Outcome depends on the skill and judgment of physician	4.47	4.40
Estimated risk of malpractice suit with poor outcome	3.60	3.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.93	4.07
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). All intensity and complexity measures indicated a high intensity and complexity. The expert panel agreed that the median physician time of 21 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.52 appropriately values 81261 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81262 Tracking Number Z9 Original Specialty Recommended RVU: **0.61**
Presented Recommended RVU: **0.61**
Global Period: XXX RUC Recommended RVU: **0.61**

CPT Descriptor: IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas) gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An enlarged inguinal lymph node and splenomegaly was found on physical examination of a 54-year-old white man who visited his internist complaining of increasing abdominal discomfort. The enlarged inguinal lymph node is excised and initial morphologic and immunologic studies demonstrate a B-cell population that is suspicious for malignancy. A lymph node sample retained frozen is submitted for Immunoglobulin heavy chain gene rearrangement Southern blot analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: A large quantity of high quality genomic DNA is isolated from the lymph node sample, and gel electrophoresis is performed to assess integrity of the extracted DNA. The DNA undergoes digestion with the 3 restriction enzymes. The genomic fragments are separated by gel electrophoresis, transferred to a nylon membrane by capillary action, and hybridized to radiolabeled probes directed toward sequences in the immunoglobulin heavy chain joining region. The pathologist evaluates the autoradiographically generated hybridization patterns of the digestion fragments in relation to marker and control lanes for evidence of clonal rearrangements or polymorphisms. The pathologist composes a report specifying the clonality status of the B-cell population. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81262		
Sample Size: 875	**Resp N:** 13	**Response:** 1.4 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	5.00	**50.00**	40.00	75.00
Survey RVW:	0.37	0.61	**0.80**	0.84	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	14.00	**20.00**	20.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81262	**Recommended Physician Work RVU: 0.61**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 2 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81262**	**Key Reference CPT Code:** 88182	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	4.00
Urgency of medical decision making	3.25	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.25
Physical effort required	3.25	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	4.00
Outcome depends on the skill and judgment of physician	4.00	4.25
Estimated risk of malpractice suit with poor outcome	4.00	4.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.75	3.50
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88182 (Work RVU = 0.77, 20 minutes). All intensity and complexity measures indicated a high intensity and complexity. The expert panel agreed that the median physician time of 20 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.61 appropriately values 81262 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81263 Tracking Number Z10 Original Specialty Recommended RVU: **0.74**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma) variable region somatic mutation analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents to his primary care physician complaining of recent fatigue, early satiety, and a 5 – 10 lb. weight loss. The patient has generalized lymphadenopathy and a palpable spleen tip. The complete blood count demonstrates lymphocytosis with anemia and thrombocytopenia. The peripheral blood smear shows an excess of small lymphocytes, occasional prolymphocytes, and smudge cells. Flow cytometry confirms a diagnosis of chronic lymphocytic leukemia. A blood specimen is submitted for IgVH sequencing to assess for somatic hypermutation in the leukemic cells.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to two multiplex PCR reactions utilizing primers directed at the leader, framework 1 and junctional regions of the immunoglobulin heavy chain gene. PCR products are separated by gel electrophoresis. After purification, clonal PCR products are subjected to dideoxynucleotide sequencing. The pathologist evaluates the degree of divergence from an appropriately selected reference sequence in order to determine somatic hypermutation status. The pathologist composes a report which specifies the patient's IvGH mutation status. The report is edited, signed, and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81263		
Sample Size:	875	**Resp N:** 10	**Response:** 1.1 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	26.00	**55.00**	100.00	100.00
Survey RVW:	0.50	0.52	**0.74**	0.78	0.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	20.00	**23.00**	30.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81263	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**23.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93307	XXX	0.92	**RUC Time**	92,368

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography

Other Reference CPT Code	Global	Work RVU	Time Source
78707	XXX	0.96	**RUC Time**

CPT Descriptor Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81263**	**Key Reference CPT Code:** 88182	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	23.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**23.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.50
Urgency of medical decision making	2.75	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.75	3.50
Physical effort required	3.25	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.25
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	2.25	2.75

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88182 (Work RVU = 0.77, 20 minutes). All intensity and complexity measures indicated a high intensity and complexity. The committee also distinguished this service as a unique complex mutation analysis unlike others. The expert panel agreed that the median physician time of 23 minutes is typical and compared to the key reference service, and the median work RVU of 0.74 appropriately values 81263 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81264 Tracking Number Z11 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.58**
Global Period: XXX RUC Recommended RVU: **0.58**

CPT Descriptor: IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An enlarged supraclavicular lymph node is identified during physical examination of 62-year-old male patient at a routine physician visit. A biopsy of the enlarged node is taken and initial morphologic and immunologic studies demonstrate a B-cell population that is suspicious for malignancy. A lymph node sample is submitted for immunoglobulin kappa light chain gene rearrangement analysis for further evidence of a clonal B-lymphoid population.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from the lymph node sample and subjected to two multiplex PCR amplification reactions using fluorescently-tagged primers directed at various framework, intronic, joining and kappa-deletion regions of the immunoglobulin kappa light chain gene. Following amplification, the reaction products from each tube are separately subjected to capillary electrophoresis. The pathologist evaluates the electrophoretic tracings for one or two predominant fragments of discrete size against background polyclonal or oligoclonal peaks for evidence of clonality. The pathologist composes a report which specifies the rearrangement and clonality status of the B-cell population in the patient sample. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81264					
Sample Size:	875	**Resp N:**	23	**Response:** 2.6 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	20.00	**50.00**	63.00	300.00
Survey RVW:	0.40	0.58	**0.75**	0.86	2.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	14.00	**22.00**	30.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81264	**Recommended Physician Work RVU: 0.58**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**22.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78707	XXX	0.96	**RUC Time**	19,729

CPT Descriptor 1 Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
93016	XXX	0.45	**RUC Time**

CPT Descriptor Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 26.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81264**	**Key Reference CPT Code:** 88182	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	22.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**22.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.67
Urgency of medical decision making	3.50	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.83	4.00
Physical effort required	2.67	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.50	3.83
Outcome depends on the skill and judgment of physician	3.67	4.00
Estimated risk of malpractice suit with poor outcome	3.50	3.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.67	3.83
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88182 (Work RVU = 0.77, 20 minutes). The committee agreed that this service is similar to 81261 however it is a more complex service. In addition, the survey respondents assimilated the work to that of 88182. The expert panel agreed that the median physician time of 22 minutes is typical and compared to the key reference service, and the median work RVU of 0.75 appropriately values 81264 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81265 Tracking Number Z12 Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old man presents to his physician complaining of fatigue, dyspnea on exertion, and easy bruising. The patient's complete blood count, peripheral blood smear, flow cytometry analysis, and bone marrow examination support a diagnosis of acute myeloid leukemia. Normal cytogenetic findings and the presence of a FLT3 internal tandem duplication mutation place him at high risk for relapse following initial treatment. The patient achieves remission with induction chemotherapy, and he is referred for peripheral blood stem cell transplantation. A matched related donor is found. Stem cells are collected from the donor, and blood specimens from the patient and the donor are submitted for pre-transplant testing to identify informative short tandem repeat (STR) markers for post-transplant chimerism testing.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from the recipient and donor whole blood samples. The individual DNA isolates are each subjected to a single multiplex PCR amplification reaction that utilizes a combination of 16 primer sets directed toward 15 polymorphic STRs and the gender marker amelogenin. The donor and recipient fluorescent PCR products are separated by capillary electrophoresis. The pathologist compares the relative sizes of the PCR products from the respective electropherograms, and identifies informative alleles that can be used for post-transplant engraftment monitoring. The pathologist composes a report specifying the informative STRs for future chimerism testing. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81265		
Sample Size:	875	**Resp N:** 37	**Response:** 4.2 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	8.00	40.00	**70.00**	130.00	1000.00
Survey RVW:	0.24	0.40	**0.70**	0.92	2.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	13.00	**17.00**	25.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81265	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**17.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 1 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.31	**RUC Time**	1,260,624

CPT Descriptor 2 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 24.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81265**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	17.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**17.00**	**17.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.78	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.67
Urgency of medical decision making	2.78	2.78
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	2.67
Physical effort required	2.56	2.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	2.78
Outcome depends on the skill and judgment of physician	2.78	2.78
Estimated risk of malpractice suit with poor outcome	3.22	2.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.89	2.67
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320 (Work RVU = 0.37, 17 minutes). This service involves the analysis of more than one specimen and the expert panel agreed that the median physician time of 17 minutes is typical and compared to the key reference service, and the 25th percentile work RVU of 0.40 appropriately values 81265 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) 81265 may be billed with add on code 81265. It may be also billed at or around the time as any HLA typing codes are billed.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81266 Tracking Number Z13 Original Specialty Recommended RVU: **0.41**
Presented Recommended RVU: **0.41**
Global Period: XXX RUC Recommended RVU: **0.41**

CPT Descriptor: Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old man presents to his physician complaining of fatigue, dyspnea on exertion, and easy bruising. The patient's complete blood count, peripheral blood smear, flow cytometry analysis, and bone marrow examination support a diagnosis of acute myeloid leukemia. Normal cytogenetic findings and the presence of a FLT3 internal tandem duplication mutation place him at high risk for relapse following initial treatment. The patient achieves remission with induction chemotherapy, and he is referred for peripheral blood stem cell transplantation. Because a matched donor cannot be identified, the patient will undergo a double cord blood transplant. A blood specimen from the patient and samples of each donor cord blood are submitted for pre-transplant testing to identify informative short tandem repeat (STR) markers for post-transplant chimerism testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from the recipient whole blood and both cord blood samples. The individual DNA isolates are each subjected to a single multiplex PCR amplification reaction that utilizes a combination of 16 primer sets directed toward 15 polymorphic STRs and the gender marker amelogenin. The fluorescent PCR products from the donors and recipient are separated by capillary electrophoresis. The pathologist compares the relative sizes of the PCR products from the respective electropherograms, and identifies informative alleles that can be used for post-transplant engraftment monitoring. The pathologist composes a report which specifies the informative STRs for future chimerism testing. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81266				
Sample Size:	875	**Resp N:**	12	**Response:**	1.3 %
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	7.00	10.00	**20.00**	50.00	400.00
Survey RVW:	0.25	0.41	**0.48**	0.52	1.20
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	11.00	**15.00**	19.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81266	**Recommended Physician Work RVU: 0.41**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.31	**RUC Time**	1,260,624

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 2 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81266**	**Key Reference CPT Code:** 86320	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**17.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	2.00
Urgency of medical decision making	2.25	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.25	2.50
Physical effort required	2.75	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.50	2.00
Outcome depends on the skill and judgment of physician	2.50	2.25
Estimated risk of malpractice suit with poor outcome	2.75	2.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.75	2.25
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 86320 (Work RVU = 0.37, 17 minutes). The committee agreed that the work of 81266 more intense than 86320. In addition, the survey respondents assimilated the work to that of 88182. The expert panel agreed that the median physician time of 22 minutes is typical and compared to the key reference service, and the 25th percentile work RVU of 0.41 appropriately values 81266 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) 81266 is an add on code and it may be billed at or around the same time as a HLA typing code.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81267 Tracking Number Z14 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old man who presents with normal karyotype acute myeloid leukemia (AML) undergoes a peripheral blood stem cell transplant after achieving remission with cytarabine and anthracycline chemotherapy. Thirty days post-transplant a blood specimen from the patient is submitted for engraftment (chimerism) testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to a single multiplex PCR amplification reaction that utilizes a combination of 16 primer sets directed toward 15 polymorphic STRs and the gender marker amelogenin. The fluorescent PCR products are separated by capillary electrophoresis. The pathologist compares electropherogram to the pretransplant recipient and donor electropherograms, and analyzes the informative alleles for the relative proportions of donor and recipient DNA. The pathologist composes a report that states the percentages of donor and recipient alleles present. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81267				
Sample Size:	875	**Resp N:**	27	**Response:** 3.0 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	100.00	**110.00**	200.00	1200.00
Survey RVW:	0.37	0.45	**0.52**	0.80	1.39
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	15.00	**18.00**	21.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81267	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92093	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 2 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 37.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81267**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	18.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**18.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.50
Urgency of medical decision making	3.90	3.90
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.90	4.20
Physical effort required	3.40	3.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.10
Outcome depends on the skill and judgment of physician	4.10	4.10
Estimated risk of malpractice suit with poor outcome	3.50	3.70

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.40	3.50
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The committee agreed that the work of 81267 more intense than 88291. In addition, 81267 is similar to 81265 (Work RVU recommended = 0.40, 17 minutes) but is much more work as it involves an intense and complex comparison of analyses. The expert panel agreed that the median physician time of 18 minutes is typical and compared to the key reference service, and the median work RVU of 0.52 appropriately values 81267 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81268 Tracking Number Z15 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.51**
Global Period: XXX RUC Recommended RVU: **0.51**

CPT Descriptor: Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type
(If comparative STR analysis of recipient [using buccal swab or other germline tissue sample] and donor are performed after hematopoietic stem cell transplantation, report IXXX6-IXXX7 in conjunction with IXXX8-IXXX9 for chimerism testing)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old man who presents with normal karyotype acute myeloid leukemia (AML) undergoes a peripheral blood stem cell transplant after achieving remission with cytarabine and anthracycline chemotherapy. Thirty days post-transplant a blood specimen from the patient is submitted for engraftment (chimerism) testing.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: CD3-positive and CD33-positive cells are isolated using fluorescent antibody-based flow cytometry. High quality genomic DNA is isolated from each of these cellular fractions and subjected to a single multiplex PCR amplification reaction that utilizes a combination of 16 primer sets directed toward 15 polymorphic STRs and the gender marker amelogenin. The fluorescent PCR products are separated by capillary electrophoresis. The pathologist compares the electropherograms to the pretransplant recipient and donor electropherograms, and analyzes the informative alleles for the relative proportions of donor and recipient DNA for each cellular component. The pathologist composes a report that states the percentages of donor and recipient alleles present for each cellular component. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81268				
Sample Size:	875	**Resp N:**	23	**Response:**	2.6 %
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	50.00	**100.00**	300.00	1200.00
Survey RVW:	0.45	0.51	**0.75**	0.90	1.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	15.00	**20.00**	22.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81268	**Recommended Physician Work RVU: 0.51**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 30.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 81268**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**20.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.71
Urgency of medical decision making	4.00	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.86	4.00
Physical effort required	3.29	3.14
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.71	3.71
Outcome depends on the skill and judgment of physician	4.14	4.00
Estimated risk of malpractice suit with poor outcome	3.29	3.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.86	3.71
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The committee agreed that the work of 81268 more intense than 88291 and more work. 81268 involves more work than 81267 whereas individual cell sorting is performed and compared to baseline analyses. The survey respondents agreed that the physician work was greater than the reference code and that of 81267. The intensity and complexity indicators agree there is more work as well. The expert panel agreed that the median physician time of 20 minutes is typical and compared to the key reference service, and the median work RVU of 0.75 appropriately values 81268 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81292 Tracking Number Z16 Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.40**
Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male patient presents with fatigue and weight loss. On physical examination, occult blood is discovered in the stool. The patient's family history is positive for colon cancer in several relatives. The patient undergoes a right hemicolectomy after a large, poorly differentiated adenocarcinoma with lymphocytic infiltration is found in the right colon. Microsatellite instability testing performed on the tumor demonstrates high level instability (MSI-H). Immunohistochemical staining reveals a loss of MLH1 protein expression. Mutation testing of the tumor for the BRAF V600E mutation and MLH1 hypermethylation are negative. An anticoagulated peripheral blood sample is submitted for MLH1 gene sequencing to assess the patient for the presence of an HNPCC-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 19 individual PCR amplification reactions whose products encompass the entire coding sequence, exon-intron boundaries and portions of 5'and 3'-untranslated regions of the MLH1 gene. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variants suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report which specifies the patient's mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81292				
Sample Size:	875	**Resp N:**	4	**Response:** 0.4 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	4.00	**8.00**	45.00	150.00
Survey RVW:	0.80	0.91	**1.15**	1.36	1.40
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	15.00	**28.00**	42.00	48.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81292	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88173	XXX	1.39	**RUC Time**

CPT Descriptor Cytopathology, evaluation of fine needle aspirate; interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	12,557

CPT Descriptor 1 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	609,187

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code	Global	Work RVU	Time Source
49423	000	1.46	**RUC Time**

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 75.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81292**	**Key Reference CPT Code:** 88173	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	50.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**50.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	2.67	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	3.33	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.67
Outcome depends on the skill and judgment of physician	4.33	4.00
Estimated risk of malpractice suit with poor outcome	3.00	3.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.67
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81292 with that of new tier 2 service 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)* (Recommended Work RVU = 1.40, 60 minutes). CAP recommends a direct crosswalk of 81292 to the physician work and time of CPT code 81406, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81293 Tracking Number Z17 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old asymptomatic woman whose 45-year-old brother was recently diagnosed with colon cancer and Lynch Syndrome presents to her physician for genetic testing. The brother has a disease-associated mutation in the MLH1 gene. An anticoagulated peripheral blood sample from the asymptomatic woman is submitted for testing for this known familial mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the respective MLH1 exon that contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	81293				
Sample Size:	875	**Resp N:**	4	**Response:** 0.4 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	5.00	**28.00**	50.00	50.00
Survey RVW:	0.50	0.50	**0.51**	0.74	1.39
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	9.00	**15.00**	21.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81293	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
93285	XXX	0.52	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 75.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81293**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.33	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	3.00
Urgency of medical decision making	2.67	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.67
Physical effort required	2.33	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.00
Outcome depends on the skill and judgment of physician	3.67	3.67
Estimated risk of malpractice suit with poor outcome	3.33	2.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81293 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81293 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81294 Tracking Number Z18 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man with a family history of colon cancer undergoes a right hemicolectomy to remove a poorly differentiated colonic adenocarcinoma with lymphocytic infiltration. The tumor demonstrates high level microsatellite instability (MSI-H). Immunohistochemistry staining reveals a loss of MLH1 protein expression. Mutation testing on the tumor for the BRAF V600E mutation and MLH1 hypermethylation are negative. Prior MLH1 sequencing performed to assess the patient for the presence of an HNPCC-related mutation was negative. Deletion/duplication analysis of the MLH1 gene is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA), which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 19 exons of the MLH1 gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the MLH1 gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81294		
Sample Size:	875	**Resp N:** 3	**Response:** 0.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	101.00	**200.00**	200.00	200.00
Survey RVW:	0.40	0.45	**0.50**	0.84	1.18
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**25.00**	35.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81294	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88112	XXX	1.18	**RUC Time**

CPT Descriptor Cyto, select cell enhance tech w/ interpret (eg, liquid based slide prep methd), exc. cerv or vag

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
96406	000	0.80	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, more than 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81294**	**Key Reference CPT Code:** 88112	**Source of Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	0.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**0.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	4.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81294 with that of new tier 2 service 81405 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.80, 30 minutes). CAP recommends a direct crosswalk of 81294 to the physician work and time of CPT code 81405, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81295 Tracking Number Z19 Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.40**
Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male patient presents with fatigue and weight loss. On physical examination, occult blood is discovered in the stool. The patient's family history is positive for colon cancer in several relatives. The patient undergoes a right hemicolectomy after a large, poorly differentiated adenocarcinoma with lymphocytic infiltration is found in the right colon. Microsatellite instability testing is performed on the tumor demonstrates high level instability (MSI-H). Immunohistochemical staining reveals a loss of MSH2 protein expression. An anticoagulated peripheral blood sample is submitted for MSH2 gene sequencing to assess the patient for the presence of an HNPCC-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 16 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81295		
Sample Size:	875	**Resp N:** 2	**Response:** 0.2 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**50.00**	75.00	100.00
Survey RVW:	0.94	1.05	**1.17**	1.28	1.39
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	24.00	**33.00**	41.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81295	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88173	XXX	1.39	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	12,557

CPT Descriptor 1 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	609,187

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code	Global	Work RVU	Time Source
49423	000	1.46	**RUC Time**

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81295**	**Key Reference CPT Code:** 88173	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	50.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**50.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	2.00	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81295 with that of new tier 2 service 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)* (Recommended Work RVU = 1.40, 60 minutes). CAP recommends a direct crosswalk of 81295 to the physician work and time of CPT code 81406, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81296 Tracking Number Z20 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old asymptomatic woman whose 45 year-old brother was recently diagnosed with colon cancer and Lynch Syndrome presents to her primary care physician for genetic testing. The brother has a disease-associated mutation in the MSH2 gene. An anticoagulated peripheral blood sample from the asymptomatic woman is submitted for testing for this known familial mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the respective MSH2 exon that contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81296		
Sample Size:	875	**Resp N:** 3	**Response:** 0.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	10.00	**15.00**	23.00	30.00
Survey RVW:	0.50	0.58	**0.65**	0.71	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	13.00	**22.00**	30.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81296	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
96405	000	0.52	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, up to and including 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 66.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81296**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**28.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.50
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.50
Physical effort required	2.00	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	4.00
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	4.50	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.50	2.50
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81296 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81296 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81297 Tracking Number Z21 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non- polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man with a family history of colon cancer undergoes a right hemicolectomy to remove a poorly differentiated colonic adenocarcinoma with lymphocytic infiltration. The tumor demonstrates high level microsatellite instability (MSI-H). Immunohistochemistry staining reveals a loss of MSH2 protein expression. Prior MLH2 sequencing performed to assess the patient for the presence of an HNPCC-related mutation was negative. Deletion/duplication analysis of the MSH2 gene is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA), which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 16 exons of the MSH2 gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the MSH2 gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81297		
Sample Size:	875	**Resp N:** 3	**Response:** 0.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	13.00	**20.00**	60.00	100.00
Survey RVW:	0.50	0.50	**0.50**	0.84	1.18
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	14.00	**23.00**	32.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81297	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88112	XXX	1.18	**RUC Time**

CPT Descriptor Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.00	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
96406	000	0.80	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, more than 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 66.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81297**	**Key Reference CPT Code:** 88112	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	43.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**30.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81297 with that of new tier 2 service 81405 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.80, 30 minutes). CAP recommends a direct crosswalk of 81297 to the physician work and time of CPT code 81405, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81298 Tracking Number Z22 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male patient presents with fatigue and weight loss. On physical examination, occult blood is discovered in the stool. The patient's family history is positive for colon cancer in several relatives. The patient undergoes a right hemicolectomy after a large, poorly differentiated adenocarcinoma with lymphocytic infiltration is found in the right colon. Microsatellite instability testing is performed on the tumor demonstrates high level instability (MSI-H). Immunohistochemical staining reveals a loss of MSH6 protein expression. An anticoagulated peripheral blood sample is submitted for MSH6 gene sequencing to assess the patient for the presence of an HNPCC-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 10 individual PCR amplification reactions whose products encompass the entire coding sequence, exon-intron boundaries and portions of 5' and 3'-untranslated regions of the MSH6 gene. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report which specifies the patient's mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81298		
Sample Size:	875	**Resp N:** 3	**Response:** 0.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	15.00	**20.00**	25.00	30.00
Survey RVW:	0.80	0.87	**0.94**	1.06	1.18
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	18.00	**20.00**	30.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81298	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88112	XXX	1.18	**RUC Time**

CPT Descriptor Cyto, select cell enhance tech w/ interpret (eg, liquid based slide prep methd), exc. cerv or vag

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
96406	000	0.80	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, more than 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81298**	**Key Reference CPT Code:** 88112	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	43.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**43.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81298 with that of new tier 2 service 81405 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.80, 30 minutes). CAP recommends a direct crosswalk of 81298 to the physician work and time of CPT code 81405, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81299 Tracking Number Z23 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old asymptomatic woman whose 45-year-old brother was recently diagnosed with colon cancer and Lynch Syndrome presents to her primary care physician for genetic testing. The brother was found to have a disease-associated mutation in the MSH6 gene. An anticoagulated peripheral blood sample from the asymptomatic woman is submitted to test for an MSH6 gene known familial mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the respective MSH6 exon that contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81299		
Sample Size:	875	**Resp N:** 2	**Response:** 0.2 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	20.00	**30.00**	40.00	50.00
Survey RVW:	0.50	0.57	**0.64**	0.70	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	13.00	**20.00**	28.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81299	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
93285	XXX	0.52	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81299**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	3.00
Urgency of medical decision making	2.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	4.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	4.00	3.00
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81299 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81299 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 600
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81300 Tracking Number Z24 Original Specialty Recommended RVU: **0.65**
Presented Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man with a family history of colon cancer undergoes a right hemicolectomy to remove a poorly differentiated colonic adenocarcinoma with lymphocytic infiltration. The tumor demonstrates high level microsatellite instability (MSI-H). Immunohistochemical staining reveals a loss of MSH6 protein expression. Prior MLH6 gene sequencing performed to assess the patient for the presence of an HNPCC-related mutation was negative. Deletion/duplication analysis of the MSH6 gene is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA), which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 10 exons of the MSH6 gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the MSH6 gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81300		
Sample Size:	875	**Resp N:** 3	**Response:** 0.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	15.00	**20.00**	35.00	50.00
Survey RVW:	0.50	0.50	**0.50**	0.72	0.94
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	14.00	**23.00**	32.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81300	**Recommended Physician Work RVU: 0.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86077	XXX	0.94	**RUC Time**

CPT Descriptor Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
99408	XXX	0.65	**RUC Time**

CPT Descriptor Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 66.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81300**	**Key Reference CPT Code:** 86077	**Source of Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81300 with that of new tier 2 service 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.65, 30 minutes). CAP recommends a direct crosswalk of 81300 to the physician work and time of CPT code 81404, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81301 Tracking Number Z25 Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male patient presents with fatigue and weight loss. On physical examination, occult blood is discovered in the stool. The patient's family history is positive for colon cancer in several relatives. The patient undergoes a right hemicolectomy after a large, poorly differentiated adenocarcinoma with lymphocytic infiltration is found in the right colon. Microsatellite instability (MSI) testing is performed on the tumor and adjacent normal tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: Paraffin is removed, and DNA is isolated from the patient's tumor and normal tissue. Each DNA isolate is subjected to a multiplex PCR amplification reaction that utilizes a combination of 7 fluorescently-labeled primer sets directed toward 5 mononucleotide repeat markers (BAT-25, BAT-26, NR-21, NR-24, and MONO-27), and 2 pentanucleotide repeat markers (Penta C and Penta D). The fluorescent PCR products from the tumor and normal tissue are each separated by capillary electrophoresis. The pathologist determines the MSI status of the tumor by comparing the electrophoretic patterns generated by the PCR products from tumor and normal tissue DNA in relation to a sizing standard for each of the repeat markers, and assessing the proportion of unstable markers. The pathologist composes a report which specifies the MSI status of the tumor. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81301		
Sample Size:	875	**Resp N:** 41	**Response:** 4.6 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	20.00	**50.00**	100.00	300.00
Survey RVW:	0.32	0.50	**0.70**	0.99	2.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**20.00**	30.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81301	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 1 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
99402	XXX	0.50	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81301**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.38
Urgency of medical decision making	2.63	3.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.38
Physical effort required	2.75	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.88	3.38
Outcome depends on the skill and judgment of physician	3.25	3.50
Estimated risk of malpractice suit with poor outcome	2.88	3.38

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.50	3.50
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from 41 pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81301 is less slightly intense and complex as 88291, although they indicated it was more overall work, with a median Work RVU = 0.70. The expert panel agreed that the median physician time of 20 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.50 appropriately values new CPT code 81301 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81302 Tracking Number Z26 Original Specialty Recommended RVU: **0.65**
Presented Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2 1/2 year-old girl born to a G2P2 mother following an unremarkable pregnancy presents to her pediatrician with regression in her language and motor skills over several months. On physical examination, the patient is small, with a head circumference in the 5th percentile. She has mildly decreased muscle tone in her limbs and slight truncal ataxia. She displays occasional abnormal limb posturing, as well as repetitive hand wringing. Rett syndrome is suspected. An anticoagulated peripheral blood sample is submitted for MECP2 sequencing to assess the patient's MECP2 mutation status.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 4 individual PCR amplification reactions, the products of which encompass the entire coding sequence, intron-exon boundaries and portions of 5' and 3'-untranslated regions of the MECP2 gene. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81302		
Sample Size:	875	**Resp N:** 4	**Response:** 0.4 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	9.00	**15.00**	20.00	20.00
Survey RVW:	0.52	0.69	**0.83**	0.93	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	39.00	**55.00**	68.00	75.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81302	**Recommended Physician Work RVU: 0.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
99408	XXX	0.65	**RUC Time**

CPT Descriptor Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 75.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81302**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**30.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
Urgency of medical decision making	3.33	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	3.67
Physical effort required	3.33	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.67
Outcome depends on the skill and judgment of physician	4.00	3.67
Estimated risk of malpractice suit with poor outcome	4.00	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.33	3.67
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81302 with that of new tier 2 service 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* (Recommended Work RVU = 0.65, 30 minutes). CAP recommends a direct crosswalk of 81302 to the physician work and time of CPT code 81404, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81303 Tracking Number Z27 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14 month-old girl born to a G2P2 mother who has a known MECP2 mutation presents to her pediatrician with developmental delay. The patient's older sister was diagnosed with Rett syndrome two years previously, and a mutation in the MECP2 gene was identified. At that time, the patient's mother was tested and was found to carry the identical MECP2 mutation. An anticoagulated peripheral blood sample is submitted for MECP2 sequencing to assess the patient for the known familial MECP2 mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification reaction of the exon that contains the known familial MECP2 mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81303					
Sample Size:	875	**Resp N:**	1	**Response:** 0.1 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**5.00**	5.00	5.00
Survey RVW:	0.60	0.60	**0.60**	0.60	0.60
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	35.00	35.00	**35.00**	35.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81303	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88387	XXX	0.62	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
11900	000	0.52	**RUC Time**

CPT Descriptor Injection, intralesional; up to and including 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81303**	**Key Reference CPT Code:** 88387	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
Urgency of medical decision making	4.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	4.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.00
Outcome depends on the skill and judgment of physician	4.00	3.00
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81303 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81303 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81304 Tracking Number Z28 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2 1/2 year-old girl born to a G2P2 mother following an unremarkable pregnancy presents to her pediatrician with regression in her language and motor skills over several months. On physical examination, the patient is small with a head circumference in the 5th percentile. She has mildly decreased muscle tone in her limbs and slight truncal ataxia. She displays occasional abnormal limb posturing, as well as repetitive hand wringing. Rett syndrome is suspected. An anticoagulated peripheral blood sample was submitted to the laboratory for MECP2 sequencing, and a mutation was not detected. Deletion/duplication analysis of the MECP2 gene is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA), which involves hybridization and ligation of oligonucleotide probes specific for the 4 exons of the MECP2 gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the MECP2 gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81304					
Sample Size:	875	**Resp N:**	1	**Response:** 0.1 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**5.00**	5.00	5.00
Survey RVW:	0.80	0.80	**0.80**	0.80	0.80
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	15.00	**15.00**	15.00	15.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81304	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
11900	000	0.52	**RUC Time**

CPT Descriptor Injection, intralesional; up to and including 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81304**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	4.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.00
Outcome depends on the skill and judgment of physician	4.00	3.00
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81304 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81304 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81310 Tracking Number N29 Original Specialty Recommended RVU: **0.39**
Presented Recommended RVU: **0.39**
Global Period: XXX RUC Recommended RVU: **0.39**

CPT Descriptor: NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old man presents to his primary care physician complaining of fatigue, dyspnea on exertion, and easy bruising. The patient's hemogram demonstrates leukocytosis with 30% blasts, anemia and thrombocytopenia. The peripheral blood smear shows decreased platelets and red blood cells along with large blasts with prominent nucleoli and Auer rods. The bone marrow contains 80% blasts which demonstrate an aberrant immunophenotype (CD33/CD13-positive with some cells expressing CD34 and CD117). The karyotype of the malignant cells is normal. A sample of anticoagulated bone marrow is submitted for NPM1 exon 12 tetranucleotide insertion mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: Upon receipt of the specimen high quality genomic DNA is isolated. A single PCR amplification is performed encompassing the region which normally contains NPM1 tetranucleotide insertion mutations. The fluorescent PCR products are separated by capillary electrophoresis. The pathologist evaluates the electropherogram comparing the relative sizes of the PCR product(s) in relation to a control peak to determine the NPM1 exon 12 mutation status. The pathologist composes a report describing the NPM1 exon 12 mutation status of the patient's leukemic cells. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81310		
Sample Size:	875	**Resp N:** 26	**Response:** 2.9 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	7.00	20.00	**28.00**	50.00	100.00
Survey RVW:	0.30	0.39	**0.51**	0.71	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	8.00	**10.00**	19.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81310	**Recommended Physician Work RVU: 0.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**19.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,291,310

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
75902	XXX	0.39	**RUC Time**

CPT Descriptor Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 34.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81310**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	19.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**19.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.67
Urgency of medical decision making	3.78	3.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.22	3.56
Physical effort required	2.56	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.44	3.67
Outcome depends on the skill and judgment of physician	3.67	3.89
Estimated risk of malpractice suit with poor outcome	3.33	3.78

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.22	3.67
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81310 is less intense and complex than 88291, and the median Work RVU = 0.51. The expert panel agreed that the survey respondents underestimated the time spent creating the report and communicating the results. The expert panel therefore recommends 19 total minutes of physician time similar to 88291 (20 minutes) as typical for this service. The expert panel also agreed that the 25th percentile work RVU of 0.39 appropriately values new CPT code 81310 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81317 Tracking Number Z30 Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.40**
Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male patient presents with fatigue and weight loss. On physical examination, occult blood is discovered in the stool. The patient's family history is positive for colon cancer in several relatives. The patient undergoes a right hemicolectomy after a large, poorly differentiated adenocarcinoma with lymphocytic infiltration is found in the right colon. Microsatellite instability testing is performed on the tumor demonstrates high level instability (MSI-H). Immunohistochemical staining reveals a loss of PMS2 protein expression. An anticoagulated peripheral blood sample is submitted for PMS2 sequencing to assess the patient for the presence of an HNPCC-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 15 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report which specifies the patient's mutation status to include information from a database and literature search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81317					
Sample Size:	875	**Resp N:**	1	**Response:** 0.1 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**5.00**	5.00	5.00
Survey RVW:	1.60	1.60	**1.60**	1.60	1.60
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	60.00	60.00	**60.00**	60.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81317	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88173	XXX	1.39	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	12,557

CPT Descriptor 1 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	609,187

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code	Global	Work RVU	Time Source
49423	000	1.46	**RUC Time**

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81317**	**Key Reference CPT Code:** 88173	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	50.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**50.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	1.00	1.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81317 with that of new tier 2 service 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)* (Recommended Work RVU = 1.40, 60 minutes). CAP recommends a direct crosswalk of 81317 to the physician work and time of CPT code 81406, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 600
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81318 Tracking Number Z31 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old asymptomatic woman whose 45-year-old brother was recently diagnosed with colon cancer and Lynch Syndrome presents to her primary care physician for genetic testing. The brother has a disease-associated mutation in the PMS2 gene. An anticoagulated peripheral blood sample from the asymptomatic woman is submitted for testing for this known familial mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the respective PMS2 gene exon that contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81318					
Sample Size:	875	**Resp N:**	1	**Response:** 0.1 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**5.00**	5.00	5.00
Survey RVW:	0.62	0.62	**0.62**	0.62	0.62
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	35.00	35.00	**35.00**	35.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81318	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88387	XXX	0.62	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
99407	XXX	0.50	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81318**	**Key Reference CPT Code:** 88387	**Source of Time** RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**28.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.00	2.00
Physical effort required	2.00	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	3.00	2.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81318 with that of new tier 2 service 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* (Recommended Work RVU = 0.52, 28 minutes). CAP recommends a direct crosswalk of 81318 to the physician work and time of CPT code 81403, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81319 Tracking Number Z32 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man with a family history of colon cancer undergoes a right hemicolectomy to remove a poorly differentiated colonic adenocarcinoma with lymphocytic infiltration. The tumor demonstrates high level microsatellite instability. Immunohistochemistry staining reveals a loss of PMS2 protein expression. Prior PMS2 gene sequencing performed to assess the patient for the presence of an HNPCC-related mutation was negative. Deletion/duplication analysis of the PMS2 gene is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA previously isolated from whole blood is subjected to multiplex ligation probe ligation analysis (MLPA) which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for 13 of the 15 exons of the PMS2 gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the PMS2 gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81319		
Sample Size:	875	**Resp N:** 1	**Response:** 0.1 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**5.00**	5.00	5.00
Survey RVW:	0.94	0.94	**0.94**	0.94	0.94
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	40.00	40.00	**40.00**	40.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81319	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86077	XXX	0.94	**RUC Time**

CPT Descriptor Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11100	000	0.81	**RUC Time**	2,805,709

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.71	**RUC Time**	155,962

CPT Descriptor 2 Injection(s); single tendon origin/insertion

Other Reference CPT Code	Global	Work RVU	Time Source
96406	XXX	0.80	**RUC Time**

CPT Descriptor Chemotherapy administration; intralesional, more than 7 lesions

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 1 **% of respondents:** 100.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81319**	**Key Reference CPT Code:** 86077	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**40.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	1.00	1.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81319 with that of new tier 2 service 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* (Recommended Work RVU = 0.80, 30 minutes). CAP recommends a direct crosswalk of 81319 to the physician work and time of CPT code 881405, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81331 Tracking Number Z33 Original Specialty Recommended RVU: **0.39**
Presented Recommended RVU: **0.39**
Global Period: XXX RUC Recommended RVU: **0.39**

CPT Descriptor: SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year-old girl is brought to a pediatrician for evaluation. She has consistently been in the 5th to 10th percentile on growth charts, is somewhat developmentally delayed, and is a voracious eater. The pediatrician discusses the possibility of Prader-Willi syndrome with the parents. A sample of anticoagulated peripheral blood is submitted for SNRPN/UBE3A methylation analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from the blood sample and undergoes bisulfite modification to convert unmethylated cystosine nucleotides to uracil. Following PCR amplification using primers specific for sequences on the maternal (methylated) and paternal (unmethylated) chromosomes, the PCR products are separated on agarose gels. The pathologist evaluates the electrophoretic patterns to determine whether normal biparental inheritance is demonstrated. The pathologist composes a report which specifies the patient's SNRPN/UBE3A mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81331		
Sample Size:	875	**Resp N:** 11	**Response:** 1.2 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	8.00	**18.00**	53.00	100.00
Survey RVW:	0.22	0.39	**0.48**	0.52	1.83
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81331	**Recommended Physician Work RVU: 0.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,291,310

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
75902	XXX	0.39	**RUC Time**

CPT Descriptor Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 81.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 81331**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.40
Urgency of medical decision making	2.80	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.80	3.60
Physical effort required	2.80	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.40	3.40
Outcome depends on the skill and judgment of physician	3.40	3.40
Estimated risk of malpractice suit with poor outcome	3.20	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.60	3.40
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81331 is slightly less overall work than 88291 with the median Work RVU = 0.48, but also indicated the work was more intense than the reference code in the intra-service period. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile Work RVU of 0.39 appropriately values new CPT code 81331 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81332 Tracking Number Z34 Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 53-year-old woman with an extensive smoking history complains to her family physician that she has been experiencing modest but increasing shortness of breath. Pulmonary function studies suggest mild airflow obstruction consistent with chronic obstructive pulmonary disease. Liver enzyme studies are normal. Alpha-1-antitrypsin deficiency is part of the differential diagnosis. An anticoagulated peripheral blood sample is submitted for SERPINA1 genotype determination of the 'Z' and 'S' alleles.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to two separate PCR amplification reactions encompassing the regions of the SERPIN1A gene which code for the 'Z' and 'S' alleles. PCR amplification products are digested with different restriction endonucleases, and the digestion products are visualized separately by ethidium bromide staining following agarose gel electrophoresis. The pathologist evaluates the patterns of restriction endonuclease digestion products on gel photographs to determine the patient's mutation status for the normal 'M" as well as mutant 'Z' and 'S' alleles. The pathologist composes a report which specifies the patient's SERPINA1 mutation status. The report is edited, signed and the results are communicated to the appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81332		
Sample Size: 875	**Resp N:** 3	**Response:** 0.3 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	12.00	**13.00**	15.00	16.00
Survey RVW:	0.37	0.44	**0.50**	0.95	1.39
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	15.00	15.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81332	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.31	**RUC Time**	1,260,624

CPT Descriptor 2 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

Other Reference CPT Code	Global	Work RVU	Time Source
96902	XXX	0.41	**RUC Time**

CPT Descriptor Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 66.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81332**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	5.00	5.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	5.00
Urgency of medical decision making	3.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	5.00
Physical effort required	1.00	1.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81332 with that of new tier 2 service 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)* (Recommended Work RVU = 0.40, 15 minutes). CAP recommends a direct crosswalk of 81332 to the physician work and time of CPT code 81401, based on work described in the CPT descriptors.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81340 Tracking Number Z35 Original Specialty Recommended RVU: **0.63**
Presented Recommended RVU: **0.63**
Global Period: XXX RUC Recommended RVU: **0.63**

CPT Descriptor: TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male patient presents with fever, episodic night sweats, weight loss and lymphadenopathy. A biopsy of an enlarged supraclavicular node is taken; initial morphologic and immunologic studies demonstrate a T-cell population that is suspicious for malignancy. A frozen sample of the lymph node is submitted for T-cell antigen receptor gene, beta rearrangement studies as part of a pathologic evaluation for lymphoma.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is extracted from a lymph node sample. In order to detect a clonally rearranged population of T-cells against a background of polyclonal T-cells, 3 multiplex PCR reactions are performed using fluorescent-linked primers directed at the variable, joining, and diversity regions of the T-cell receptor beta chain genes. The resulting PCR products are separated using capillary electrophoresis. The pathologist evaluates the capillary tracing for a predominant fragment of discrete size and appropriate morphology against background polyclonal or oligoclonal peaks for evidence of clonality. The pathologist composes a report which specifies the clonality status of the T-cell population. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81340		
Sample Size:	875	**Resp N:** 28	**Response:** 3.2 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	33.00	**65.00**	100.00	300.00
Survey RVW:	0.37	0.63	**0.77**	0.94	2.79
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	15.00	**25.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81340	**Recommended Physician Work RVU: 0.63**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
65205	000	0.71	**RUC Time**	35,304

CPT Descriptor 1 Removal of foreign body, external eye; conjunctival superficial

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
92615	XXX	0.63	**RUC Time**

CPT Descriptor Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81340**	**Key Reference CPT Code:** 88182	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	25.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**25.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.14	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.29	4.00
Urgency of medical decision making	4.00	4.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.57	4.57
Physical effort required	3.00	3.14
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.29	4.29
Outcome depends on the skill and judgment of physician	4.57	4.57
Estimated risk of malpractice suit with poor outcome	4.29	4.29

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.86	3.86
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 88182 (Work RVU = 0.77, 20 minutes). The survey respondents indicated code 81340 is slightly less intense and complex than 88182. However, the respondents also equated the new code's overall work with that of 88182, with a median Work RVU = 0.77. The expert panel agreed that the median physician time of 25 minutes is typical and compared to the key reference service, the survey's 25th percentile work RVU of 0.63 appropriately values new CPT code 81210 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81341 Tracking Number Z36 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male patient presents with fever, episodic night sweats, weight loss and lymphadenopathy. A biopsy of an enlarged supraclavicular node is taken; initial morphologic and immunologic studies demonstrate a T-cell population that is suspicious for malignancy. T-cell gene rearrangement studies performed using PCR analysis are indeterminate. A frozen sample of the lymph node is submitted to the laboratory for Southern blot analysis to further assessm for a clonally rearranged population of T-cells.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: A large quantity of high quality genomic DNA is isolated from the lymph node sample. Gel electrophoresis of the extracted DNA is performed to assess DNA integrity. The DNA undergoes digestion with 3 restriction enzymes. The genomic fragments are separated by gel electrophoresis, transferred to a nylon membrane by capillary action, and hybridized to radiolabeled probes directed toward the TCRB joining regions (Jβ1 and 2). The pathologist evaluates the autoradiographically generated hybridization patterns of the digestion fragments in relation to marker and control lanes to determine T-cell clonality status. The pathologist composes a report which specifies the clonality status of the T-cell population. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81341		
Sample Size:	875	**Resp N:** 8	**Response:** 0.9 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	6.00	**18.00**	44.00	80.00
Survey RVW:	0.50	0.56	**0.65**	0.83	0.94
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	19.00	**19.00**	31.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81341	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**19.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	19,291,310

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,186,775

CPT Descriptor 2 Fundus photography with interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 37.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81341**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	19.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**19.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.00	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	4.00	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.67	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey results and agreed that the number of survey respondents was extremely low and that conclusions could not be drawn from the data. The expert panel assimilated the overall physician work of 81341 with that of CPT code 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)* (Recommended Work RVU = 0.45, 12 minutes). However the expert panel agreed that the survey median time of 19 minutes accurately reflects the typical time required to perform this service. CAP recommends a direct crosswalk of 81341 to the physician Work RVU of 88388 at 0.45 RVUs and a total physician time of 19 minutes, based on time, physician work effort, and intensity and complexity of the service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81342 Tracking Number Z36 Original Specialty Recommended RVU: **0.57**
Presented Recommended RVU: **0.57**
Global Period: XXX RUC Recommended RVU: **0.57**

CPT Descriptor: TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male patient presents with fever, episodic night sweats, weight loss and lymphadenopathy. A biopsy of an enlarged supraclavicular node is taken; initial morphologic and immunologic studies demonstrate a T-cell population that is suspicious for malignancy. A frozen sample of the lymph node is submitted for T-cell antigen receptor gene, gamma rearrangement studies as part of a pathologic evaluation for lymphoma.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is extracted from a lymph node sample. In order to detect a clonally rearranged population of T-cells against a background of polyclonal T-cells, 2 multiplex PCR reactions are performed using fluorescent linked primers directed toward the variable and joining regions of the T-cell receptor gamma genes. The resulting PCR products are separated using capillary electrophoresis. The pathologist evaluates the capillary tracing for a predominant fragment of discrete size and appropriate shape against background polyclonal or oligoclonal peaks for evidence of clonality. The pathologist composes a report which specifies the clonality status of the T-cell population. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81342					
Sample Size:	875	**Resp N:**	50	**Response:** 5.7 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	30.00	**85.00**	163.00	500.00
Survey RVW:	0.37	0.57	**0.77**	0.94	2.80
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	15.00	**25.00**	30.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81342	**Recommended Physician Work RVU: 0.57**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	105,397

CPT Descriptor 1 Debridement of extensive eczematous or infected skin; up to 10% of body surface

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11721	000	0.54	**RUC Time**	7,622,371

CPT Descriptor 2 Debridement of nail(s) by any method(s); 6 or more

Other Reference CPT Code	Global	Work RVU	Time Source
76881	XXX	0.58	**RUC Time**

CPT Descriptor Ultrasound, extremity, nonvascular, real-time with image documentation; complete

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81342**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	25.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**25.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.07	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.87	3.87
Urgency of medical decision making	3.73	3.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.93	3.93
Physical effort required	3.20	3.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.73
Outcome depends on the skill and judgment of physician	4.07	4.00
Estimated risk of malpractice suit with poor outcome	3.67	3.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.87	3.87
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from 50 pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81342 takes more time

and work than 88291. The survey's median Work RVU=0.77, and median time = 25 minutes. The survey respondents also indicated overall that the intensity and complexity of the new code is greater than the key reference code. The expert panel agreed that the median physician time of 25 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.57 appropriately values new CPT code 81342 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81350 Tracking Number Z38 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male patient presents with fatigue and weight loss. The patient is found to have poorly differentiated adenocarcinoma of the colon with unresectable metastases to the liver. Despite 5-FU, leucovorin, and oxaliplatin (FLOFOX) therapy, the patient's disease progresses, and irinotecan therapy is recommended. Prior to beginning irinotecan treatment, an anticoagulated peripheral blood sample is submitted to test the patient's UGT1A1 promoter TA repeat numbers.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the region containing the UGT1A1 promoter TA repeat segment. The fluorescent products are subjected to analysis using capillary electrophoresis. The pathologist evaluates the electropherogram and compares it to a sizing ladder to determine the patient's genotype. Based on this analysis, the pathologist composes a report which specifies the patient's genotype. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81350					
Sample Size:	875	**Resp N:**	10	**Response:** 1.1 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	7.00	**10.00**	13.00	20.00
Survey RVW:	0.32	0.37	**0.48**	0.55	0.55
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	15.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81350	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics & molecular cytogenetics, interpret & report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
96446	XXX	0.37	**RUC Time**

CPT Descriptor Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 2 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81350**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.00
Urgency of medical decision making	4.50	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.50
Physical effort required	4.00	3.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	4.00
Outcome depends on the skill and judgment of physician	4.50	4.00
Estimated risk of malpractice suit with poor outcome	4.50	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.50
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81350 takes 15 minutes

to provide with less overall work than the key reference service. (median Work RVU = 0.48) The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.37 appropriately values new CPT code 81350 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 750
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81355 Tracking Number Z5 Original Specialty Recommended RVU: **0.38**
Presented Recommended RVU: **0.38**
Global Period: XXX RUC Recommended RVU: **0.38**

CPT Descriptor: VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents to his physician with complaints of fatigue, lightheadedness, and palpitations. A diagnostic workup revealed atrial fibrillation, for which the physician would like to prescribe warfarin. In order to facilitate rapid achievement of the proper dose, she orders warfarin sensitivity genotyping for common variants of the VKORC1 gene, which have been shown to significantly influence the dose of warfarin needed to achieve appropriate therapeutic levels. A sample of peripheral blood is submitted for genotypic analysis of the VKORC1 gene.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to a multiplexed PCR reaction, using primers specific for the most common variants, VKORC1 (-1639A). The amplified target DNA is hybridized to a ferrocene signal probe and to an allele-specific capture probe, which is immobilized on an oligoarray. The captured target DNA generates a specific electrochemical signal that identifies the target DNA sequence. The pathologist examines the patient's results and analytic system controls, and determines whether VKORC1 variants are present in the patient's sample. The pathologist composes a report which specifies the patient's genotype. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81355		
Sample Size:	875	**Resp N:** 12	**Response:** 1.3 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	18.00	20.00	**20.00**	60.00	100.00
Survey RVW:	0.30	0.38	**0.50**	0.71	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	11.00	**15.00**	19.00	40.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81355	**Recommended Physician Work RVU: 0.38**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	2

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
93790	XXX	0.38	**RUC Time**

CPT Descriptor Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81355**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**17.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.50	2.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.25
Physical effort required	2.25	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.25	3.00
Outcome depends on the skill and judgment of physician	3.25	3.00
Estimated risk of malpractice suit with poor outcome	3.25	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.25	2.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data from pathologists who perform the service and compared it to the key reference code 86320 (Work RVU = 0.37, 17 minutes). The survey respondents indicated code 81355 is more intense and complex as 86320 and the median Work RVU = 0.50. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.38 appropriately values new CPT code 81355 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81370 Tracking Number Z39 Original Specialty Recommended RVU: **0.54**
Presented Recommended RVU: **0.54**
Global Period: XXX RUC Recommended RVU: **0.54**

CPT Descriptor: HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old man with insulin dependent diabetes mellitus has end stage renal disease for which he is receiving dialysis treatment. The patient is found to be a suitable renal transplant candidate, and HLA typing is requested for listing on the UNOS kidney registry for potential recipients. A sample of anticoagulated peripheral blood is submitted to the laboratory for low resolution HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1 testing.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic regions containing the HLA-A, -B, -C, -DRB1/3/4/5 and -DQB1 loci are amplified by PCR using a series of 142 sequence specific primer sets. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of amplicon patterns and with the assistance of computer software, the pathologist determines the HLA type for the HLA-A, -B, -C, DRB1/3/4/5, and –DQB1 loci. The pathologist composes a report which specifies the patient's HLA type at the low resolution level. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	81370					
Sample Size:	171	**Resp N:**	30	**Response:** 17.5 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	30.00	100.00	**200.00**	510.00	2000.00
Survey RVW:	0.35	0.54	**0.77**	0.90	2.20
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	10.00	**15.00**	30.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81370	**Recommended Physician Work RVU: 0.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 2 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81370**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.80
Urgency of medical decision making	3.70	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	4.10
Physical effort required	3.20	3.10
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.90	3.90
Outcome depends on the skill and judgment of physician	3.40	3.20
Estimated risk of malpractice suit with poor outcome	3.90	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.40	3.30
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The 30 survey respondents indicated 813730 requires more physician work and is more complex or intense in 7 out of 9 measures compared to the key reference service. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.54 appropriately values 81370 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81371 Tracking Number Z40 Original Specialty Recommended RVU: **0.77**
Presented Recommended RVU: **0.60**
Global Period: XXX RUC Recommended RVU: **0.60**

CPT Descriptor: HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with acute myelogenous leukemia with unfavorable cytogenetics is in his first remission. The patient will require a hematopoietic stem cell transplant. A potential HLA matched unrelated donor has been identified through the National Marrow Donor Program. Prior to final donor selection, a sample of anticoagulated peripheral blood is submitted to the laboratory for low resolution typing for HLA-A, -B, -DRB1/3/4/5 to confirm the recipient's typing and donor match.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic regions containing the HLA-A, -B, -DRB1/3/4/5 loci are amplified by PCR using a series of 95 sequence specific primer sets. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA type for the HLA-A, -B, and -DRB1/3/4/5 loci, and compares the results to the original high resolution typing used for the donor search to verify the original typing result. The pathologist composes a report which specifies the patient's HLA type from both analyses. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81371		
Sample Size: 171	**Resp N:** 15	**Response:** 8.7 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	50.00	**100.00**	200.00	600.00
Survey RVW:	0.40	0.60	**0.77**	0.94	1.10
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	10.00	**30.00**	30.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81371	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86077	XXX	0.94	**RUC Time**

CPT Descriptor Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 2 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 26.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81371**	**Key Reference CPT Code:** 86077	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**40.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.75
Urgency of medical decision making	4.75	4.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.75	4.75
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	4.50	4.75
Estimated risk of malpractice suit with poor outcome	5.00	5.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.50	4.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 86077 (Work RVU = 0.94, 40 minutes). The survey respondents indicated that new code 81371 requires less physician work than the reference code. The expert panel agreed that the median physician time of 30 minutes is typical and compared to the key reference service, the median work RVU of 0.77 appropriately values 81371 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81372 Tracking Number Z41 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old woman has a history of diffuse large cell lymphoma. The patient has undergone chemotherapy and has been multiply transfused. She has become refractory to platelet transfusion as a result of antibodies to Class I HLA antigens. A sample of anticoagulated peripheral blood is submitted to the laboratory for low resolution HLA-A, -B, -C testing to initiate a search for an HLA matched platelet unit for transfusion.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic regions containing the HLA-A, -B, -C loci are amplified by PCR using a series of 95 sequence specific primer sets. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA type for the HLA-A, -B, and -C loci. The pathologist composes a report which specifies the patient's HLA type at the low resolution level. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81372		
Sample Size:	171	**Resp N:** 15	**Response:** 8.7 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	25.00	**50.00**	100.00	600.00
Survey RVW:	0.37	0.52	**0.62**	0.77	1.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	5.00	**15.00**	20.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81372	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 1 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 26.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81372**	**Key Reference CPT Code:** 88182	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.25
Urgency of medical decision making	3.75	3.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.50	4.50
Physical effort required	3.50	3.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	4.25	4.25
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.25	4.25
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88182 (Work RVU = 0.77, 20 minutes). The survey respondents indicated 81372 requires less physician work than the reference code yet this service has a high intensity and complexity within the HLA family. The expert panel agreed that the median physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.52 appropriately values 81372 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81373 Tracking Number Z42 Original Specialty Recommended RVU: **0.37**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, B, or -C), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old woman has a complex array of symptoms and signs that indicate the presence of an autoimmune disorder. Several disorders with HLA-B associations are considered. A sample of anticoagulated peripheral blood is submitted to the laboratory for HLA-B typing.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA-B locus is amplified by PCR using 47 sequence-specific primers sets. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA type for the HLA-B locus. The pathologist composes a report which specifies the patient's HLA-B type at the low resolution level. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81373		
Sample Size: 171	**Resp N:** 15	**Response:** 8.7 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	35.00	**60.00**	88.00	600.00
Survey RVW:	0.15	0.37	**0.38**	0.60	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	4.00	**7.00**	15.00	18.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81373	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 1 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	0

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
94060	XXX	0.31	**RUC Time**

CPT Descriptor Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 46.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81373**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**15.00**	**17.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.14	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.29
Urgency of medical decision making	2.00	2.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.71	2.86
Physical effort required	1.57	1.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.57	2.71
Outcome depends on the skill and judgment of physician	2.00	2.71
Estimated risk of malpractice suit with poor outcome	2.43	2.43

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.43	2.43
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 86320 (Work RVU = 0.37, 17 minutes). The survey respondents assimilated the physician work of 81373 to the key reference service. The expert panel agreed that the survey respondents underestimated the total time for the service. Specifically the CAP expert panel agreed that the interpretation and report time was underestimated. The expert panel agreed that a total physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.37 appropriately values 81373 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81374 Tracking Number Z43 Original Specialty Recommended RVU: **0.34**
Presented Recommended RVU: **0.34**
Global Period: XXX RUC Recommended RVU: **0.34**

CPT Descriptor: HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old man has suspected ankylosing spondylitis. A sample of anticoagulated peripheral blood is submitted to the laboratory for HLA-B*27 testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA-B locus is amplified with the PCR using a set of primers specific for HLA-B27. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA-B*27 status. The pathologist composes a report which specifies the patient's HLA-B*27 status. The report is edited, signed and the results communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81374		
Sample Size: 171	**Resp N:** 10	**Response:** 5.8 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	30.00	**60.00**	60.00	3000.00
Survey RVW:	0.20	0.34	**0.40**	0.55	0.77
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	3.00	**4.00**	13.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81374	**Recommended Physician Work RVU: 0.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**13.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.31	**RUC Time**	1,260,624

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81374**	**Key Reference CPT Code:** 86320	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	13.00	17.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**13.00**	**17.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.67	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.33	2.33
Urgency of medical decision making	2.33	2.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.67	2.33
Physical effort required	1.67	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.67	2.33
Outcome depends on the skill and judgment of physician	1.67	2.33
Estimated risk of malpractice suit with poor outcome	1.67	2.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.00	2.33
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 86320 (Work RVU = 0.37, 17 minutes). The survey respondents indicated the physician work of 81374 was slightly greater than the key reference service however less intense and complex. The expert panel agreed that the survey respondents underestimated the total time for the service. Specifically the CAP expert panel agreed that the interpretation and report time was underestimated. The expert panel agreed that a total physician time of 13 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.34 appropriately values 81374 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81375 Tracking Number Z44 Original Specialty Recommended RVU: **0.60**
Presented Recommended RVU: **0.60**
Global Period: XXX RUC Recommended RVU: **0.60**

CPT Descriptor: HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28-year-old man is being considered as a potential hematopoietic stem cell donor for his sister who has been diagnosed with acute myelogenous leukemia. He and the other asymptomatic siblings were initially typed for Class I HLA (HLA-A,-B,-C). He was found to be a full match for his sister at these loci. A sample of anticoagulated peripheral blood is submitted to the laboratory for low resolution HLA-DRB1/3/4/5 and -DQB1 typing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA-DRB1/3/4/5 and -DQB1 loci are amplified by PCR using 48 sequence-specific primer sets. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA type for the HLA-DRB1/3/4/5, and –DQB1 loci. The pathologist composes a report which specifies the donor's HLA-DRB1/3/4/5 and –DQB1 type at the low resolution level and assesses the match with the recipient. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81375		
Sample Size: 171	**Resp N:** 11	**Response:** 6.4 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	20.00	**100.00**	152.00	450.00
Survey RVW:	0.45	0.60	**0.75**	0.85	1.56
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	10.00	**15.00**	16.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81375	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 1 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93307	XXX	0.92	**RUC Time**	92,368

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 36.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81375**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.75
Urgency of medical decision making	4.00	2.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	2.75
Physical effort required	3.00	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	2.75
Outcome depends on the skill and judgment of physician	4.00	2.75
Estimated risk of malpractice suit with poor outcome	3.50	2.25

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	2.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated the physician work of 81375 is much greater than the key reference service as the median Work RVU was 0.75. In addition all of the intensity and complexity measures indicated that 81375 is much more complex and intense than 88291. The expert panel agreed that a total physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile Work RVU of 0.60 appropriately values 81375 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81376 Tracking Number Z45 Original Specialty Recommended RVU: **0.62**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man is being considered as a potential kidney donor for a friend with end stage renal disease. The potential recipient has antibodies against multiple HLA-DQ antigens and will be incompatible with 85% of the donor pool. The physician wishes to screen the potential donor for HLA-DQB1 before proceeding with a full donor work-up. A sample of anticoagulated peripheral blood from the potential donor is submitted to the laboratory for HLA-DQB1 typing.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA -DQB1 loci is amplified by PCR using 24 sequence-specific primer sets. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA type for the HLA–DQB1 locus. The pathologist composes a report which specifies the patient's HLA-DQB1 type at the low resolution level. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81376		
Sample Size:	171	**Resp N:** 12	**Response:** 7.0 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	33.00	**50.00**	100.00	350.00
Survey RVW:	0.40	0.50	**0.62**	0.79	1.20
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	8.00	**15.00**	15.00	27.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81376	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88182	XXX	0.77	**RUC Time**

CPT Descriptor Flow cytometry, cell cycle or DNA analysis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77300	XXX	0.62	**RUC Time**	1,695,583

CPT Descriptor 1 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
65205	XXX	0.71	**RUC Time**	35,304

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival superficial

Other Reference CPT Code	Global	Work RVU	Time Source
93279	XXX	0.65	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81376**	**Key Reference CPT Code:** 88182	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.00	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.25	4.25
Physical effort required	3.25	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.75	4.00
Outcome depends on the skill and judgment of physician	4.25	4.00
Estimated risk of malpractice suit with poor outcome	4.75	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	3.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88182 (Work RVU = 0.77, 20 minutes). The survey respondents indicated the physician work of 81376 is less physician work than the key reference service as the median Work RVU was 0.62. However, the all intensity and complexity measures indicated that 81376 is similar in complexity and intensity as 88291. The expert panel agreed that a total physician time of 15 minutes is typical and compared to the key reference service, the median Work RVU of 0.62 appropriately values 81376 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81377 Tracking Number Z46 Original Specialty Recommended RVU: **0.43**
Presented Recommended RVU: **0.43**
Global Period: XXX RUC Recommended RVU: **0.43**

CPT Descriptor: HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman presents to an ophthalmologist for ocular pain and photophobia. She has been suffering headaches and dizziness for several weeks. Upon examination, the doctor finds signs of posterior uveitis and observes vitiligo on her face and her arms. He suspects Vogt-Koyanagi-Harada (VKH), an autoimmune disease strongly associated with HLA-DR4. A sample of anti-coagulated peripheral blood is submitted to the laboratory for HLA-DR4 typing.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to PCR amplification using a set of primers specific for the HLA-DRB1*04 allele group. A series of negative and positive control DNA samples are run in parallel. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines a digitized image or photograph of the ethidium bromide stained gel to assess the presence or absence of amplicons produced for the allele group-specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines the HLA-DRB1*04 status. The pathologist composes a report which specifies the patient's HLA-DRB1*04 status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81377		
Sample Size: 171	**Resp N:** 9	**Response:** 5.2 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	10.00	**19.00**	20.00	1000.00
Survey RVW:	0.40	0.43	**0.51**	0.71	1.05
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	4.00	**15.00**	17.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81377	**Recommended Physician Work RVU: 0.43**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 44.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 81377**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.75	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	3.25
Urgency of medical decision making	1.75	2.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.25	3.25
Physical effort required	2.25	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.50	3.00
Outcome depends on the skill and judgment of physician	2.75	3.25
Estimated risk of malpractice suit with poor outcome	2.50	2.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.75	3.25
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated the physician work of 81377 is less than the key reference service as the median Work RVU was 0.51. The expert panel also referenced CPT code 88388 (Work RVU = 0.45, 12 minutes total time) as a good comparison code. The expert panel agreed that a total physician time of 15 minutes is typical and compared to the key reference service, the 25th percentile Work RVU of 0.43 appropriately values 81377 within this family of services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81378 Tracking Number Z47 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with acute myelogenous leukemia with unfavorable cytogenetics is in his first remission. The patient will require a hematopoietic stem cell transplant and has no siblings. A sample of anticoagulated peripheral blood is submitted to the laboratory for high resolution HLA-A, -B, -C and -DRB1 testing to search for an HLA matched donor through the National Marrow Donor Program.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DA is isolated from whole blood. The genomic regions containing the HLA-A, -B, -C and DRB1 genes are amplified by PCR using locus specific primers. For each locus, the PCR products are sequenced with a series of forward and reverse primers. The pathologist visually analyzes the DNA sequences obtained and assesses their alignment against a consensus sequence and comparison with a database of all known alleles with the assistance of software. Ambiguities are resolved using sequence specific primers. Based on these analyses, the pathologist assigns an HLA type for HLA-A, -B, -C and DRB1 at the allele level. The pathologist composes a report which specifies the patient's HLA type. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81378		
Sample Size: 171	**Resp N:** 17	**Response:** 9.9 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	60.00	**107.00**	300.00	1000.00
Survey RVW:	0.77	0.92	**1.02**	1.35	2.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	15.00	**20.00**	30.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81378	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 35.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 81378**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.75
Urgency of medical decision making	4.00	2.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	2.75
Physical effort required	3.00	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	2.75
Outcome depends on the skill and judgment of physician	4.00	2.75
Estimated risk of malpractice suit with poor outcome	3.50	2.25

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	2.75
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and agreed that the survey respondents overestimated the physician work, but not the time involved. The expert panel agreed with the survey respondent's median time of 20 minutes for this service, as the typical time required. The expert panel assimilated the overall physician work with that of recently RUC reviewed service 88388 (Work RVU = 0.45, 12 minutes). CAP recommends a direct crosswalk of 81378 to the physician work of 88388 (Work RVU = 0.45) and a total time of 20 minutes for CPT code 81378.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81379 Tracking Number Z48 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with acute myelogenous leukemia is being considered for a hematopoietic stem cell transplant from an unrelated donor. The potential recipient has been previously typed by high resolution for HLA Class II and low resolution for HLA-A, -B, and –C in an unsuccessful attempt to identify a related donor. To select the best unrelated donor, high resolution typing of the patient is necessary. A sample of anticoagulated peripheral blood is submitted to the laboratory for high resolution HLA-A, -B, and -C allele identification.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic regions containing the HLA-A, -B, and -C genes are amplified by PCR using locus specific primers. For each locus, the PCR products are sequenced with a series of forward and reverse primers. The pathologist evaluates the DNA sequences obtained, assesses their alignment against a consensus sequence and compares results against a database of all known alleles with the assistance of computer software. Ambiguities are resolved using sequence specific primers. Based on these analyses, the pathologist assigns an HLA type for HLA-A, -B, and -C at the allele level. The pathologist composes a report which specifies the patient's HLA type. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81379		
Sample Size: 171	**Resp N:** 9	**Response:** 5.2 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	50.00	**100.00**	300.00	1000.00
Survey RVW:	0.75	0.77	**0.80**	1.18	1.95
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	10.00	**15.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81379	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86077	XXX	0.94	**RUC Time**

CPT Descriptor Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81379**	**Key Reference CPT Code:** 86077	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.33	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.33
Urgency of medical decision making	4.33	4.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	4.33
Physical effort required	4.00	3.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	4.33
Outcome depends on the skill and judgment of physician	4.33	4.33
Estimated risk of malpractice suit with poor outcome	4.33	4.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.33	4.33
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and agreed that the survey respondents overestimated the physician work, but not the time involved. The expert panel agreed with the survey respondent's median time of 15 minutes for this service, as the typical time required. The expert panel assimilated the overall physician work with that of recently RUC reviewed service 88388 (Work RVU = 0.45, 12 minutes). CAP recommends a direct crosswalk of 81379 to the physician work of 88388 (Work RVU = 0.45) and a total time of 15 minutes for CPT code 81379.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81380 Tracking Number Z49 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old woman with acute myelogenous leukemia is being considered for a hematopoietic stem cell transplant from a related donor. Low resolution HLA typing of the patient and several family members identifies a brother who is a potential 2 haplotype match. However, four closely related HLA-B allele groups are segregating in the family, calling into question whether the patient and her brother have inherited identical HLA-B alleles. High resolution typing of the B locus of the patient and her brother is required to resolve this ambiguity. A sample of anticoagulated peripheral blood from the patient is submitted to the laboratory for high resolution HLA-B locus testing to assess her HLA-B allele type for comparison to her brother's type.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic regions containing the HLA-B gene are amplified by PCR using locus specific primers. The resulting PCR products are sequenced with a series of forward and reverse primers. The pathologist evaluates the DNA sequences obtained, assesses their alignment against a consensus sequence and compares results against a database of all known alleles with the assistance of computer software. Ambiguities are resolved using sequence specific primers. Based on these analyses, the pathologist assigns an HLA type for HLA-B at the allele level. The pathologist composes a report which specifies the patient's HLA type and assesses the match with the potential donor. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81380		
Sample Size:	171	**Resp N:** 9	**Response:** 5.2 %
Sample Type:	Convenience	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**10.00**	59.00	200.00
Survey RVW:	0.50	0.51	**0.62**	0.79	0.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	6.00	**15.00**	18.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81380	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86077	XXX	0.94	**RUC Time**

CPT Descriptor Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81380**	**Key Reference CPT Code:** 86077	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.33
Urgency of medical decision making	4.33	4.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	4.33
Physical effort required	2.67	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	4.33
Outcome depends on the skill and judgment of physician	4.33	4.33
Estimated risk of malpractice suit with poor outcome	4.33	4.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.00	4.33
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and agreed that the survey respondents overestimated the physician work, but not the time involved. The expert panel agreed with the survey respondent's median time of 15 minutes for this service, as the typical time required. The expert panel assimilated the overall physician work with that of recently RUC reviewed service 88388 (Work RVU = 0.45, 12 minutes). CAP recommends a direct crosswalk of 81380 to the physician work of 88388 (Work RVU = 0.45) and a total time of 15 minutes for CPT code 81380.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81381 Tracking Number Z50 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An antiretroviral regimen including the drug abacavir is planned for a 35-year-old man with a diagnosis of HIV-1. Prior to beginning abacavir treatment, a sample of anticoagulated peripheral blood is submitted to the laboratory for HLA-B*57:01 allele testing.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA-B locus is amplified by PCR, and the amplicons are interrogated in hybridization reactions with 100 oligonucleotide probes immobilized on fluorescent microscopic beads. Fluorescence is then assessed in a fluorescent bead array assay. The pathologist examines the fluorescent intensities seen with each probe and determines the status of the HLA-B*57 allele group with the assistance of computer software. Testing with additional probes to distinguish HLA-B*57:01 from other B*57 alleles is performed if necessary. Based on these analyses, the pathologist determines the status of the HLA-B*57:01 allele. The pathologist composes a report which specifies the patient's HLA-B*57:01 allele status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81381		
Sample Size: 171	**Resp N:** 11	**Response:** 6.4 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	31.00	**50.00**	80.00	150.00
Survey RVW:	0.25	0.47	**0.53**	0.80	0.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	5.00	**7.00**	15.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code: 81381	**Recommended Physician Work RVU: 0.45**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**12.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 36.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 81381**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	12.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**12.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.75	2.75
Urgency of medical decision making	3.25	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.25	3.00
Physical effort required	2.25	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.25	3.50
Outcome depends on the skill and judgment of physician	2.75	3.00
Estimated risk of malpractice suit with poor outcome	3.50	2.75

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.50	3.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and agreed that the survey respondents overestimated the physician work and underestimated the time required. The expert panel assimilated the overall physician work with that of recently RUC reviewed service 88388 (Work RVU = 0.45, 12 minutes). CAP recommends a direct crosswalk of 81381 to the physician work and time of CPT code 88388.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81382 Tracking Number Z51 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with acute myelogenous leukemia with unfavorable cytogenetics is in his first remission. The patient will require a hematopoietic stem cell transplant and has no siblings. In addition to high resolution HLA-A, -B, -C and DRB1 testing, the physician requests that HLA-DQB1 be included in the search for an HLA matched donor through the National Marrow Donor Program. A sample of anticoagulated peripheral blood is submitted to the laboratory for HLA-DQB1 allele typing.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA Class II gene is amplified by PCR using locus specific primers. The PCR products are sequenced with a series of forward and reverse primers. The pathologist evaluates the DNA sequences obtained, assesses their alignment against a consensus sequence and compares results against a database of all known alleles with the assistance of computer software. Ambiguities are resolved using sequence specific primers.. Based on these analyses, the pathologist assigns an HLA type at the allele level. The pathologist composes a report which specifies the patient's HLA-DQB1 alleles. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81382		
Sample Size: 171	**Resp N:** 10	**Response:** 5.8 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	5.00	**30.00**	188.00	600.00
Survey RVW:	0.62	0.78	**0.85**	0.90	0.94
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	5.00	**15.00**	15.00	22.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81382	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81382**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.80	5.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	5.00
Urgency of medical decision making	4.80	5.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	5.00
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	5.00	5.00
Estimated risk of malpractice suit with poor outcome	4.80	5.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	47.80	5.00
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and agreed that the survey respondents overestimated the physician work but not the time required. The expert panel agrees with the median survey time of 15 minutes as the typical time required to provide this service. The expert panel assimilated the overall physician work with that of recently RUC reviewed service 88388 (Work RVU = 0.45, 12 minutes). CAP recommends a direct crosswalk of 81382 to the physician work of 88388 of 0.45 Work RVUs and total time of 15 minutes for CPT code 81382.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81383 Tracking Number Z52 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman describes excessive daytime sleepiness over the past two months and a recent single episode of transient weakness resulting in her collapse to the floor while discussing a family member's recent death. The results of a polysomnogram and a multiple sleep latency test are indeterminate in helping reach a diagnosis of narcolepsy. A sample of anticoagulated peripheral blood is submitted to the laboratory for HLA-DQB1*06:02 allele identification.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood. The genomic region containing the HLA-DQB1 locus is PCR amplified using sets of sequence specific primers to detect HLA-DQB1*06 group alleles and to distinguish among DQB1*06 alleles. The amplicons produced are separated by size via gel electrophoresis. The pathologist examines the digitized images or photographs of the ethidium bromide stained gels to assess the presence or absence of amplicons produced for the specific reactions in comparison to positive and negative controls. Based on the manual analysis of the amplicon patterns and with the assistance of computer software, the pathologist determines whether the HLA–DQB1*06:02 allele is present. The pathologist composes a report which specifies the patient's HLA-DQB1*06:02 allele status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Jeffrey A. Kant MD PhD FCAP FAAAS, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists		
CPT Code:	81383		
Sample Size: 171	**Resp N:** 11	**Response:** 6.4 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	6.00	20.00	**30.00**	32.00	300.00
Survey RVW:	0.37	0.40	**0.52**	0.80	0.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	5.00	**15.00**	15.00	22.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81383	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,096,399

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93016	XXX	0.45	**RUC Time**	1,112,086

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
88388	XXX	0.45	**RUC Time**

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81383**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.33	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	3.67	4.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	4.00
Physical effort required	3.00	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.33	4.33
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.67	3.76

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.25	4.33
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and agreed that the survey respondents overestimated the physician work and time. The expert panel assimilated the overall physician work with that of recently RUC reviewed service 88388 (Work RVU = 0.45, 12 minutes). CAP recommends a Work RVU crosswalk of 81383 to the physician work of CPT code 88388 and the intra-service median survey time of 15 minutes total.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

59 New Molecular Pathology Services

Global Period:_XXX Meeting Date: _September 2011

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

TAB 5 – All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011), except for the HLA code set where CAP surveyed several large and small labs throughout the United States. Survey responses were compiled; questions and clarifications were followed up with lab managers and directors. CAP's expert panel reviewed compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment for all codes.

TAB 9 – All practice expenses were cross-walked to already reviewed Tier 2 codes (April 2011).

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Molecular DNA analyses based on specific code.

Intra-Service Clinical Labor Activities:

NONE

Post-Service Clinical Labor Activities:
Clean up, document filing, and other activities, see spreadsheet

	A	B	C	D
1	**TAB 5 - Final Recommendation**			**81210**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Cross walk from 88XX8 and 88XX23 (DNA extraction from parriffin)** *Typical Batch Size - 2*			*BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant*
3		**CMS Code**	**Staff Type**	**Total Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**111**
6	*Lab Tech*			*18*
7	*Cytotechnologist*			*93*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**100**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	6
16	Cutting sections from specimen block using microtome			
17	Removal of paraffin			
18	DNA extraction using extraction instrument			
19	Dilution of DNA extraction 1:5 or 1:10			
20	Discard DNA extraction waste (liquids and solids)			
21	**PCR Set Up**	L045A	Cytotechnologist	13
22	Assemble PCR Primers, buffer, etc… into plates			
23	Combine reagents for PCR master mix			
24	Place tips, PCR reagents and PCR reaction plate on liquid handling instrument 2			
25	Remove extracted DNA from DNA extraction instrument and place on liquid handling system 2			
26	Allow instrument to set up PCR reaction			
27	Cover plate with sealing mat			
28	Place PCR reaction plate in thermal cycler, enter PCR program, and allow instrument to perform PCR			
29	Discard liquid handling system 2 tips from PCR set up			
30	**Check gel**	L045A	Cytotechnologist	13
31	Spin down PCR plate			
32	Mix, heat, cool and pour ethidium bromide containing agarose gel			
33	Combine 8uL of PCR product with 2uL of loading buffer			
34	Add samples, controls and ladder to agarose gel			
35	Photograph gel			
36	Save image and annotate			
37	**PCR Post Processing 1**	L045A	Cytotechnologist	17
38	Prepare EXO/SAP mix			
39	Add mix to PCR products on plate			
40	Place on thermal cycler			
41	**Dye Term Cycle**	L045A	Cytotechnologist	13
42	Prepare sequencing plates			
43	Prepare sequencing Big Dye master mix			
44	Aliquot Big Dye master mix			
45	Add template			
46	Seal, vortex, spin			
47	Place on thermal cycler			
48	**Dye Term Purification**	L045A	Cytotechnologist	24
49	Make fresh Sodium Acetate/ETOH			
50	Add to sequencing samples			
51	Spin down for 20 min			
52	Invert plate on towels			
53	Quick spin plate			
54	Make fresh 70% ETOH			
55	Add ETOH to wells			
56	Spin for 5 min			
57	Add formamide and sequencing standard			
58	Cover with septa and quick spin			

	A	B	C	D
1	**TAB 5 - Final Recommendation**			**81210**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Cross walk from 88XX8 and 88XX23 (DNA extraction from parriffin)** *Typical Batch Size - 2*			*BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant*
3		**CMS Code**	**Staff Type**	**Total Minutes**
59	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure “OUT” stack is empty			
60	**Sequencing**	L045A	Cytotechnologist	5
61	Load plate onto sequencer			
62	Create new sample sheet using batch name/sample number			
63	Check capillary array after run is completed			
64	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
65	**End: When specimen is ready for examination by physician**			
66	**Service Period**			
67				
68	**Post-Service Period**			
69	**Start: When specimen examination by physician is complete**			
70	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
71	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
72	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
73	Clean Room	L033A	Lab Tech	2
74	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
75	Perform scheduled data management back-up	L033A	Lab Tech	1
76	**End: When specimen, chemical waste and record handling is complete**			
77	**SUPPLIES**		**Type of Unit**	**No. of Units**
78	DNA isolation kit		reaction	1
79	Gown	SB027	item	1
80	Gloves, nonsterile	SB022	pair	5
81	Bleach 10%	SL020	ml	1.5
82	High fidelity hot start Taq polymerase		ul	0.5
83	PCR buffer		ul	10
84	MgCl2		ul	3
85	F Primer		ul	2
86	R Primer		ul	2
87	dNTPs		ul	2
88	PCR grade water	SL244	ul	68
89	Ethidium bromide (10 mg/ml)	SL239	ul	5
90	DNA ladder, 100bp		ul	5
91	Loading buffer with dye	SL210	ul	20
92	Agarose ultrapure		g	0.8
93	Agarose NuSieve GTG		g	1.6
94	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
95	Masking tape		inch	12
96	96 Capillary array		item	1/200
97	Cycle sequencing kit		ul	16
98	Cycle sequencing purification plates		each	1
99	Optical 96 well reaction plate		each	1
100	Sequencing primers		ul	4
101	0.2 ml strip tubes		each	1
102	0.2 ml PCR tubes		each	2
103	Barrier pipet tips1000 uL		ul	1
104	Barrier pipet tips 200 uL		each	3
105	Barrier pipet tips 20uL		each	15
106	Milli-Q water		ml	35
107	Exonuclease 1 / Shrimp alkaline phosphatase		ul	4
108	Formamide	SL192	ul	30
109	Septa		each	0.3
110	Polymer		ul	1/125
111	Sequencing cassette		each	1
112	Running buffer		ul	80
113	15 mL centrifuge tubes	SL241		2
114	50 mL centrifuge tubes			2

	A	B	C	D
1	**TAB 5 - Final Recommendation**			**81210**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Cross walk from 88XX8 and 88XX23 (DNA extraction from parriffin)** *Typical Batch Size - 2*			*BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant*
3		**CMS Code**	**Staff Type**	**Total Minutes**
115	2 mL plastic tubes		each	1
116	0.5 mL microcentrifuge tubes			2
117	Extraction tubs		each	4
118	Extraction tip assembly		each	1
119	100% ethanol	SL189	ml	50
120	Xylene	SL151	ml	50
121	Micro tubes 2.0 mL		item	2
122	Micro tubes, 1.5 mL with caps		item	4
123	Microtube, 1.5 mL with locking lid		item	1
124	Gauze, 4 x 4	SG051	item	1
125	Kimwipe	SM027	item	2
126	**Equipment**			**Time in Use Minutes**
127	Analytical balance		EP004	1
128	Capillary electrophoresis instrument, 96 well - sequencing			12
129	Centrifuge		EP059	3
130	Cooling block			3
131	Gel electrophoresis apparatus with power supply		EP063	15
132	Gel imaging system			4
133	Micro-volume spectrophotometer with specimen retention technology			1
134	Nucleic acid extraction instrument			5
135	Nucleic acid workstation			13
136	Pipet set		EP071	20
137	Thermal cycler			50
138	Water bath		EP043	10
139	Solvent recycler system			2

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81225**	**81226**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX2*			*CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	*CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**49**	**49**
6	*Lab Tech*	*L033A*		*18*	*18*
7	*Cytotechnologist*	*L045A*		*31*	*31*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**38**	**38**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
11	**PRE-SERVICE**				
12	**Start: When preparing containers/requisitions for physician begins**				
13	**Confirm** orders	L033A	Lab Tech	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4
16	Extraction (run set up)				
17	Extraction (aliquoting, instrument set up, DNA concentration)				
18	**PCR Set Up**	L045A	Cytotechnologist	13	13
19	Generate run on computer, generate a run on computer, and prepare tray map				
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)				
21	Retrieve sample, position on tray map				
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix				
23	Aliqout mastermix and sample to well				
24	Vortex and spin sample				
25	Set up Thermocycler and load samples				
26	Remove samples from thermocycler				
27					
28	**Bead Hybirdization:**	L045A	Cytotechnologist	12	12
29					
30					
31					
32	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
33	**End: When specimen is ready for examination by physician**				
34	**Service Period**				
35					
36	**End: When specimen is ready for examination by physician**				
37	**Post-Service Period**				
38	**Start: When specimen examination by physician is complete**				
39	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
40	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
41	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
42	Clean Room	L033A	Lab Tech	2	2
43	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
44	Perform scheduled data management back-up	L033A	Lab Tech	1	1
45	**End: When specimen, chemical waste and record handling is complete**				
46	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
47	DNA isolation kit		reaction	1	1
48	Gown	SB027	item	0.5	0.5
49	Gloves, nonsterile	SB022	pair	2.5	2.5
50	Bleach 10%	SL020	ml	0.75	0.75
51	High fidelity hot start Taq polymerase		ul	0.75	0.75
52	PCR buffer		ul	15	15
53	MgCl2		ul	4.5	4.5
54	F Primer, fluorescent		ul	3	3
55	R Primer, fluorescent		ul	3	3
56	dNTPs		ul	3	3
57					
58	Ethidium bromide (10 mg/ml)	SL239	ul	5	5
59	DNA ladder, 100bp		ul	5	5
60	Loading buffer with dye	SL210	ul	20	20
61	Agarose ultrapure		g	0.8	0.8
62	Agarose NuSieve GTG		g	1.6	1.6
63	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100
64	Milli-Q water		ml	40	40
65	Masking tape		inch	12	12
66	0.2 mL strip tubes		each	2	2
67	0.5 mL microcentrifuge tubes			2	2
68	2 mL plastic tubes		each	2	2
69	PCR grade water	SL244	ul	228	228
70	Barrier pipet tips1000 uL		ul	1	1
71	Barrier pipet tips 200 uL		each	3	3
72	Barrier pipet tips 20uL		each	10	10
73	Running buffer		ul	10	10
74	Formamide	SL192	ul	30	30
75	Size standard		ul	2.6	2.6

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81225**	**81226**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX2*			*CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	*CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
76	Optical 96 well reaction plate		each	1	1
77	Septa		each	0.3	0.3
78	Polymer		ul	3:40	3:40
79	Capillary array		item	1/200	1/200
80	Cassette		each	1	1
81	Extraction tubs		each	4	4
82	Extraction tip assembly		each	1	1
83					
84	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
85	Analytical balance		EP004	1	1
86					
87					
88	Centrifuge		EP059	2	2
89	Cooling block			1	1
90					
91					
92	Micro-volume spectrophotometer with specimen retention technology			1	1
93	Nucleic acid extraction instrument			5	5
94	Nucleic acid workstation			13	13
95	Pipet set		EP071	14	14
96	Thermal cycler			25	25
97	Water bath		EP043	5	5
98	Luminex Instrument			20	20

	A	B	C	F	G
1	**TAB 5 - FINAL RECOMMENDATION**			**81227**	**81335**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX2*			*CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	*VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, 1639/3673)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**49**	**49**
6	*Lab Tech*	*L033A*		*18*	*18*
7	*Cytotechnologist*	*L045A*		*31*	*31*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**38**	**38**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
11	**PRE-SERVICE**				
12	**Start: When preparing containers/requisitions for physician begins**				
13	**Confirm** orders	L033A	Lab Tech	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4
16	Extraction (run set up)				
17	Extraction (aliquoting, instrument set up, DNA concentration)				
18	**PCR Set Up**	L045A	Cytotechnologist	13	13
19	Generate run on computer, generate a run on computer, and prepare tray map				
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)				
21	Retrieve sample, position on tray map				
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix				
23	Aliqout mastermix and sample to well				
24	Vortex and spin sample				
25	Set up Thermocycler and load samples				
26	Remove samples from thermocycler				
27					
28	**Bead Hybirdization:**	L045A	Cytotechnologist	12	12
29					
30					
31					
32	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
33	**End: When specimen is ready for examination by physician**				
34	**Service Period**				
35					
36	**End: When specimen is ready for examination by physician**				
37	**Post-Service Period**				
38	**Start: When specimen examination by physician is complete**				
39	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
40	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
41	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
42	Clean Room	L033A	Lab Tech	2	2
43	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
44	Perform scheduled data management back-up	L033A	Lab Tech	1	1
45	**End: When specimen, chemical waste and record handling is complete**				
46	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
47	DNA isolation kit		reaction	1	1
48	Gown	SB027	item	0.5	0.5
49	Gloves, nonsterile	SB022	pair	2.5	2.5
50	Bleach 10%	SL020	ml	0.75	0.75
51	High fidelity hot start Taq polymerase		ul	0.75	0.75
52	PCR buffer		ul	15	15
53	MgCl2		ul	4.5	4.5
54	F Primer, fluorescent		ul	3	3
55	R Primer, fluorescent		ul	3	3
56	dNTPs		ul	3	3
57					
58	Ethidium bromide (10 mg/ml)	SL239	ul	5	5
59	DNA ladder, 100bp		ul	5	5
60	Loading buffer with dye	SL210	ul	20	20
61	Agarose ultrapure		g	0.8	0.8
62	Agarose NuSieve GTG		g	1.6	1.6
63	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100
64	Milli-Q water		ml	40	40
65	Masking tape		inch	12	12
66	0.2 mL strip tubes		each	2	2
67	0.5 mL microcentrifuge tubes			2	2
68	2 mL plastic tubes		each	2	2
69	PCR grade water	SL244	ul	228	228
70	Barrier pipet tips1000 uL		ul	1	1
71	Barrier pipet tips 200 uL		each	3	3
72	Barrier pipet tips 20uL		each	10	10
73	Running buffer		ul	10	10
74	Formamide	SL192	ul	30	30
75	Size standard		ul	2.6	2.6

	A	B	C	F	G
1	**TAB 5 - FINAL RECOMMENDATION**			**81227**	**81335**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX2*			*CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	*VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, 1639/3673)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
76	Optical 96 well reaction plate		each	1	1
77	Septa		each	0.3	0.3
78	Polymer		ul	3:40	3:40
79	Capillary array		item	1/200	1/200
80	Cassette		each	1	1
81	Extraction tubs		each	4	4
82	Extraction tip assembly		each	1	1
83					
84	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
85	Analytical balance		EP004	1	1
86					
87					
88	Centrifuge		EP059	2	2
89	Cooling block			1	1
90					
91					
92	Micro-volume spectrophotometer with specimen retention technology			1	1
93	Nucleic acid extraction instrument			5	5
94	Nucleic acid workstation			13	13
95	Pipet set		EP071	14	14
96	Thermal cycler			25	25
97	Water bath		EP043	5	5
98	Luminex Instrument			20	20

	A	B	C	D	E	F
1	**TAB 5 - FINAL RECOMMENDATION**			**81245**	**81310**	**81350**
2	**Meeting Date: September 2011** **Specialty: Pathology Crosswalk to L2** *Adjusted for Batch Size - 4*			*FLT3 (fms-related tyrosine kinase 3)* (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	*NPM1 (nucleophosmin)* (eg, acute myeloid leukemia) gene analysis, exon 12 variants	*UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**62**	**62**	**62**
6	*Lab Tech*	*L033A*		*18*	*18*	*18*
7	*Cytotechnologist*	*L045A*		*44*	*44*	*44*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**51**	**51**	**51**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**					
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**
11	**PRE-SERVICE**					
12	**Start: When preparing containers/requisitions for physician begins**					
13	**Confirm** orders	L033A	Lab Tech	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4	4
16	Extraction (run set up)					
17	Extraction (aliquoting, instrument set up, DNA concentration)					
18	**PCR Set Up**	L045A	Cytotechnologist	13	13	13
19	Generate run on computer, generate a run on computer, and prepare tray map					
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)					
21	Retrieve sample, position on tray map					
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix					
23	Aliqout mastermix and sample to well					
24	Vortex and spin sample					
25	Set up Thermocycler and load samples					
26	Remove samples from thermocycler					
27						
28						
29						
30						
31	**PCR Post Processing**	L045A	Cytotechnologist	25	25	25
32	Post-PCR -Prepare loading master mix					
33	Dilute sample					
34	Denature/cool samples					
35	Load sample onto instrument					
36	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2	2
37	**End: When specimen is ready for examination by physician**					
38	**Service Period**					
39						
40	**End: When specimen is ready for examination by physician**					
41	**Post-Service Period**					
42	**Start: When specimen examination by physician is complete**					
43	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2
44	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2
46	Clean Room	L033A	Lab Tech	2	2	2
47	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2
48	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1
49	**End: When specimen, chemical waste and record handling is complete**					
50	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**	**No. of Units**
51	DNA isolation kit		reaction	1	1	1
52	Gown	SB027	item	0.5	0.5	0.5
53	Gloves, nonsterile	SB022	pair	2.5	2.5	2.5
54	Bleach 10%	SL020	ml	0.75	0.75	0.75
55	High fidelity hot start Taq polymerase		ul	0.75	0.75	0.75
56	PCR buffer		ul	15	15	15
57	MgCl2		ul	4.5	4.5	4.5
58	F Primer, fluorescent		ul	3	3	3
59	R Primer, fluorescent		ul	3	3	3

	A	B	C	D	E	F
1	**TAB 5 - FINAL RECOMMENDATION**			**81245**	**81310**	**81350**
2	**Meeting Date: September 2011** **Specialty: Pathology Crosswalk to L2** *Adjusted for Batch Size - 4*			*FLT3 (fms-related tyrosine kinase 3)* (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	*NPM1 (nucleophosmin)* (eg, acute myeloid leukemia) gene analysis, exon 12 variants	*UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
60	dNTPs		ul	3	3	3
61						
62	Ethidium bromide (10 mg/ml)	SL239	ul	5	5	5
63						
64						
65						
66						
67						
68	Milli-Q water		ml	40	40	40
69						
70	0.2 mL strip tubes		each	2	2	2
71	0.5 mL microcentrifuge tubes			2	2	2
72	2 mL plastic tubes		each	2	2	2
73	PCR grade water	SL244	ul	228	228	228
74	Barrier pipet tips1000 uL		ul	1	1	1
75	Barrier pipet tips 200 uL		each	3	3	3
76	Barrier pipet tips 20uL		each	10	10	10
77	Running buffer		ul	10	10	10
78	Formamide	SL192	ul	30	30	30
79	Size standard		ul	2.6	2.6	2.6
80	Optical 96 well reaction plate		each	1	1	1
81	Septa		each	0.3	0.3	0.3
82	Polymer		ul	3:40	3:40	3:40
83	Capillary array		item	1/200	1/200	1/200
84	Cassette		each	1	1	1
85	Extraction tubs		each	4	4	4
86	Extraction tip assembly		each	1	1	1
87						
88	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
89	Analytical balance		EP004	1	1	1
90	Capillary electrophoresis instrument - fragment analysis			15	15	15
91	Capillary electrophoresis instrument - fragment analysis software			15	15	15
92	Centrifuge		EP059	2	2	2
93	Cooling block			1	1	1
94	Gel electrophoresis apparatus with power supply		EP063	8	8	8
95	Gel imaging system			2	2	2
96	Micro-volume spectrophotometer with specimen retention technology			1	1	1
97	Nucleic acid extraction instrument			5	5	5
98	Nucleic acid workstation			13	13	13
99	Pipet set		EP071	14	14	14
100	Thermal cycler			25	25	25
101	Water bath		EP043	5	5	5

	A	B	C	D	E	F	G
1	**TAB 5 - FINAL RECOMMENDATION**			**81261**	**81264**	**81340**	**81342**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX3*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**59**	**59**	**59**	**59**
6	*Lab Tech*	*L033A*		*18*	*18*	*18*	*18*
7	*Cytotechnologist*	*L045A*		*41*	*41*	*41*	*41*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**48**	**48**	**48**	**48**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**						
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**	**11**
11	**PRE-SERVICE**						
12	**Start: When preparing containers/requisitions for physician begins**						
13	**Confirm** orders	L033A	Lab Tech	1	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6	6	6
15	**DNA Extraction**	L045A	Cytotech	4	4	4	4
16	place blood sample on rocker						
17	Place tips and microtiter plate on Qiagen 9604						
18	Remove cap from blood tube						
19	place blood sample in Qiagen 9604 rack and allow instrument to read bar code and aliquot blot into microtiter plate						
20	Create plate map for testing and IT interface						
21	Cap blood tube and return specimen to refrigerator until testing completed						
22	Place tips, reagents and microtiter plates on Qiagen M96						
23	Place microtiter plate with blood sample on Qiagen M96						
24	Allow instrument to extract DNA						
25	discard DNA extraction waste (liquids and solids)						
26	**PCR Set Up**	L045A	Cytotech	15	15	15	15
27	combine reagents for PCR master mix			5 master mixes	2 master mixes		
28	Place tips, PCR reagents and PCR reaction plate on Biomek 2000						
29	Remove extracted DNA from Qiagen M96 and place on Biomek 2000						
30	Allow instrument to set up PCR reaction						
31	Cover plate with sealing mat						
32	discard Biomek 2000 tips from PCR set up						
33	Place PCR reaction plate in ABI 9700 thermal cycler, enter Accutype PCR program, and allow instrument to perform PCR						
34							
35							
36	**Post PCR Processing 3**	L045A	Cytotech	20	20	20	20
37	combine reagents for loading master mix						
38	Place tips, 2nd digest plate, loading plate, dilution plate, nuclease free water, ROX size standard and Hi-Di foramide on Biomek 2000 and allow instrument to pipet reagents						
39	Place 3130 loading plate on ABI 9700, enter denature program, and allow thermal cycler to denature						
40	Cover plate with 96-well septa						
41	discard Biomek 2000 tips from loading set up						
42	Prepare 3130 instrument for capillary electrophoresis (upload plate map, add buffer, POP4, capillary array, 16-well septa)						
43	Place loading reaction plate into casette and place on 3130 instrument						
44	Allow instrument to perform capillary electrophoresis						

	A	B	C	D	E	F	G
1	**TAB 5 - FINAL RECOMMENDATION**			**81261**	**81264**	**81340**	**81342**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX3*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**	**Minutes**
45	**Review sample and prepare data for physician interpretation**	L045A	Cytotech	2	2	2	2
46	**End: When specimen is ready for examination by physician**						
47	**Service Period**						
48							
49	**Post-Service Period**						
50	**Start: When specimen examination by physician is complete**						
51	Enter results in lab information system after physician interp	L033A	Lab Tech	2	2	2	2
52	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2	2
53	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2	2
54	Clean Room	L033A	Lab Tech	2	2	2	2
55	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2	2
56	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1	1
57	**End: When specimen, chemical waste and record handling is complete**						
58							
59	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**	**No. of Units**	**No. of Units**
60	DNA isolation		reaction	1	1	1	1
61	Gown	SB027	item	0.5	0.5	0.5	0.5
62	Gloves, nonsterile	SB022	pair	2.5	2.5	2.5	2.5
63	Bleach 10%	SL020	ml	0.75	0.75	0.75	0.75
64	100% ethanol	SL189	ml	0.44	0.44	0.44	0.44
65	1000uL graduated barrier pipet tips		each	3	3	3	3
66	10mL serological pipet		item	1	1	1	1
67							
68	11 Primer Pairs		ul	2 uL	2 uL	2 uL	2 uL
69	20 uL barrier pipe tips		each	7	7	7	7
70	200uL barrier pipet tips		each	3	3	3	3
71	20uL pipet barrier tips		each	4	4	4	4
72	25 mL pipettes		item	1	1	1	1
73	250uL barrier pipet tips		each	3	3	3	3
74	8-cap strips		each	0.13	0.13	0.13	0.13
75	96 well PCR Plate		each	0.03	0.03	0.03	0.03
76							
77							
78							
79	Capillary Array 16X36Cm		item	0.063	0.063	0.063	0.063
80	Capillary electrophoresis buffer		ul	0.007	0.007	0.007	0.007
81	Capillary electrophoresis polymer		ul	5.2	5.2	5.2	5.2
82	Capillary electrophoresis size standard		ul	0.5	0.5	0.5	0.5
83	Disposable culture tubes 12X75		each	0.01	0.01	0.01	0.01
84	DNA extraction instrument tips		item	6	6	6	6
85	dNTPs		ul	0.4	0.4	0.4	0.4
86							
87	Formamide	SL192	item	0.01	0.01	0.01	0.01
88	green microtiter plates		each	0.01	0.01	0.01	0.01
89	High fidelity hot start taq polymerase		ul	0.3	0.3	0.3	0.3
90	Liquid handling instrument tips		item	1	1	1	1
91	Microcentrifuge tubes	SL240	each	1	1	1	1
92							
93	Plate Sealers		each	0.01	0.01	0.01	0.01
94	Reagent, Water, Sterile Nuclease Free, 100Ml	SL251	ul	26	26	26	26
95	Sealing mat		each	0.03	0.03	0.03	0.03
96	Septa Strip Tray 96 well		item	0.04	0.04	0.04	0.04
97	Strip Tube, 8 Per Strip		each	0.1	0.1	0.1	0.1

	A	B	C	D	E	F	G
1	**TAB 5 - FINAL RECOMMENDATION**			**81261**	**81264**	**81340**	**81342**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX3*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**	**Minutes**
98	Tube, Thin Wall Pcr 8 Strip W/Cap 200uL		each	0.1	0.1	0.1	0.1
99	U bottom microtiter plates		each	0.01	0.01	0.01	0.01
100	yellow microtiter plates		each	0.01	0.01	0.01	0.01
101							

	A	B	C	D	E	F	G
1	**TAB 5 - FINAL RECOMMENDATION**			**81261**	**81264**	**81340**	**81342**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Crosswalked to L2XXX3*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**	**Minutes**
102	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
103	Capillary electrophoresis instrument - fragment analysis			15	15	15	15
104	Capillary electrophoresis instrument - fragment analysis software			15	15	15	15
105	Micro-volume spectrophotometer with specimen retention technology			1	1	1	1
106	Nucleic acid extraction instrument			5	5	5	5
107	Nucleic acid workstation			15	15	15	15
108	Pipet set		EP071	20	20	20	20
109	Thermal cycler			54	54	54	54

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81262**	**81341**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 2* *Referenced to 88XX16*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**		
4	**Global Period**				
5	**TOTAL CLINICAL LABOR TIME**			**104**	**104**
6	*Lab Tech*	L033A		18	18
7	*Cytotechnologist*	L045A		86	86
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**93**	**93**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
11	**PRE-SERVICE**				
12	**Confirm** orders	L033A	Lab Tech	1	1
13	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
14	Retrieve and accession specimen: Receiving sample, checking for unacceptable conditions.				
15	Gather reports and history on patient.				
16	Check blood tube against requisition				
17	Log in patient with accession ID				
18	Print out labels				
19	Setup extraction labels				
20	**EXTRACTION and Reaction**	L045A	Cytotechnologist	10	10
21	Gather all needed cartriages, internal control, and elution tubes, reagents and racks. Inspect cartriage integrity and fill volume in wells.				
22	Prepare lymph node specimen for extraction				
23	Label and add specimen to 1.5ml sample tube and place elution tube on DNA extraction instrument				
24	Load onto DNA extraction instrument, set up run conditions, and run				
25	Check DNA concentration and 260/280 ratio on NanoDrop				
26	Label patient tubes				
27	Dilute DNA				
28	Prepare 3 restriction enzyme digestion reaction mixes				
29	Aliquot restriction digestion reaction mixes into tubes, add diluted DNA for patient and control to reaction mix in each tube (6 total tubes)				
30	Place in incubator				
31	**Gel**	L045A	Cytotechnologist	40	40
32	Prepare Gel				
33	Add Dye to samples				
34	Load gel				
35	Gel picture				
36	HCL				
37	NacL/NaOH				
38	NacL/Tris				
39	Prepare for blotting: Transfer DNA gel to Nytran membrane using turboblotter, wash membrane				

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81262**	**81341**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 2* *Referenced to 88XX16*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**		
40	Blot the membrane dry and wrap in UV-transparent plastic wrap				
41	**Post Processing 1: PreHyb+Hyb**	L045A	Cytotechnologist	9	9
42	Prehyb				
43	Aliquot probe mix				
44	Put probe on ice				
45	Mix probe with hyb solution				
46	Add probe to blot + cap container				
47	**Post Processing 2: Stringency washes**	L045A	Cytotechnologist	5	5
48	Wash 1				
49	Wash 2				
50	**Post Processing 3: Detection**	L045A	Cytotechnologist	20	20
51	Wash 1				
52	Wash 2				
53	Prepare wash 3 (buffer + probe)				
54	Wash 3				
55	Wash 4				
56	Detection Buffer				
57	CPD				
58	Place film in cassette				
59	Expose Film				
60	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
61	**End: When specimen is ready for examination by physician**				
62	**Post-Service Period**				
63	**Start: When specimen examination by physician is complete**				
64	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
65	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
66	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
67	Clean Room	L033A	Lab Tech	2	2
68	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
69	Perform scheduled data management back-up	L033A	Lab Tech	1	1
70	**End: When specimen, chemical waste and record handling is complete**				
71					
72	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
73	DNA isolation		reaction	1	1
74	Bleach 10%	SL020	ml	0.75	0.75
75	Extraction tip assembly		each	1	1
76	Extraction tubs		each	4	4
77	Milli-Q water		ml	35	35
78	Masking tape		inches	12	12
79	1.5 mL tubes	SL240	tubes	5.88	5.88
80	AGAROSE		g	1.76	1.76
81	Anti-Dig Antibody		mcL	2.35	2.35
82	Blood collection (6mL, purple top)	SL242	unit	1.18	1.18
83	Blotting paper		sheet	1.18	1.18
84	Boric Acid		g	3.24	3.24
85	Bromophenol Blue		g	1.18	1.18
86	Chemiluminescent detection reagent		mL	1.18	1.18

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81262**	**81341**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 2* *Referenced to 88XX16*			IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
3		**CMS Code**	**Staff Type**		
87	Coriell controls		mcL	2.94	2.94
88	Dig Easy Hyb		mL	47.65	47.65
89	Digoxigenin Labeled Probe		mcL	11.76	11.76
90	DNA ladder, 100bp		mcL	23.53	23.53
91					
92	BAMH1		unit	150.00	150.00
93	HINDIII		unit	80.00	80.00
94	EcoR1		unit	40.00	40.00
95	EDTA		g	10.94	10.94
96	Ficoll		g	2.12	2.12
97	Film		film	1.18	1.18
98	Filtered, 1000mcL		tips	11.76	11.76
99	Filtered, 10mcL		tips	70.59	70.59
100	Filtered, 200mcL		tips	70.59	70.59
101	Filtered, 20mcL		tips	70.59	70.59
102	gloves, non-sterile	SB022	pair	1.00	1.00
103	gown, staff, impervious	SB027	item	0.75	0.75
104	HCL	SL178	mL	4.71	4.71
105	Large Volume Compact		cartrid	2.35	2.35
106	NaOH (Pellets), ACS	SL128	g	4.82	4.82
107	Nylon Membrane		sheet	1.18	1.18
108	Potassium Phosphate		g	0.48	0.48
109	Sheet protector	SK044	sheet	1.18	1.18
110	Sodium Chloride	SL126	g	142.99	142.99
111	Sodium Citrate	SL127	g	41.51	41.51
112	Sodium Dodecyl Sulfate		g	11.76	11.76
113	Sodium Phosphate		g	11.76	11.76
114	Spermidine		g	0.03	0.03
115	SYBR Gel Stain		mcL	17.65	17.65
116	Tris Base		g	20.60	20.60
117	Wash and Blocking Buffer Set		blot	1.18	1.18
118	Xylene Cyanol		g	1.18	1.18
119					
120	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
121	37 degree incubator		EPO21	600	600
122	Analytical balance		EP004	1	2
123	Gel electrophoresis apparatus with power supply		EP063	600	600
124	Gel imaging system			4	4
125	Micro-volume spectrophotometer with specimen retention technology			7	7
126	Nucleic acid extraction instrument			9	9
127	Pipet set		EP071	6	6
128	Water bath		EP043	22	22

	A	B	C	D
1	**TAB 5-FINAL RECOMMENDATION**			**81263**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Referenced Code = L2XXX4*			*IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**97**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*79*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**86**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**Preserve RNA**	L045A	Cytotechnologist	2
16	Preparing work area, materials, documentation, and labeling			
17	Red blood cell lysis, white blood cell lysis, and freezing of specimen			
18	**RNA isolation**	L045A	Cytotechnologist	2
19	Preparing work area, materials, and documentation			
20	Isolating and quantitating RNA			
21	**mRNA Preparation**	L045A	Cytotechnologist	8
22	Adding reagents and mixing			
23	Incubating, washing, centrifuging, and quantitating			
24	**cDNA preparation**	L045A	Cytotechnologist	10
25	Preparing reagents, materials, controls, documentation			
26	Assembling master mix, adding to tubes along with specimen and controls; mixing and incubating			
27	Decontaminating area with bleach			
28	**Initial PCR reaction**	L045A	Cytotechnologist	15
29	Preparing reagents, documentation, labeling			
30	Preparing master mix, adding to reaction tubes along with cDNA, mixing, programming thermal cycler, adding and removing reaction tubes from thermal cycler			
31				
32				
33				
34	**Confirm PCR products**	L045A	Cytotechnologist	13
35	Preparing samples for electrophoresis, reagents, documentation and preparing agarose gel			
36	Loading samples into agarose gel, performing electorphoresis, photographing gel in darkroom, and decontaminating transilluminator			
37	**PCR Clean-up**	L045A	Cytotechnologist	3
38	Preparing documentation and labeling			
39	Adding ExoSAP-IT, mixing, programming thermal cycler adding and removing from thermal cycler			
40	**Cycle Sequencing Reaction**	L045A	Cytotechnologist	10
41	Preparing reagents, documentation, and labeling plate			
42	Assembling master mix, adding to plate along with reagents, amplicons, mixing, centrifuging programming thermal cycler, adding and removing from thermal cycler			
43	**Ethanol Precipitation**	L045A	Cytotechnologist	8
44	Preparing reagents, including fresh 70% ethanol, and documentation			
45	Adding reagents, mixing, centrifuging, incubating, heating, cooling			
46	**Sequencing**	L045A	Cytotechnologist	6
47	Preparing documentation and entering run parameters			
48	Placing plate in sequencer and running instrument, exporting data to file			
49	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
50	**End: When specimen is ready for examination by physician**			
51	**Service Period**			
52				
53	**Post-Service Period**			
54	**Start: When specimen examination by physician is complete**			
55	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2

	A	B	C	D
1	**TAB 5-FINAL RECOMMENDATION**			**81263**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Referenced Code = L2XXX4*			*IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
3		**CMS Code**	**Staff Type**	**Minutes**
56	Prepare, pack and transport specimens and records for in-house storage and external storage		Lab Tech	2
57	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
58	Clean Room	L033A	Lab Tech	2
59	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
60	Perform scheduled data management back-up	L033A	Lab Tech	1
61	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	**TAB 5-FINAL RECOMMENDATION**			**81263**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *Referenced Code = L2XXX4*			*IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
3		**CMS Code**	**Staff Type**	**Minutes**
62	**SUPPLIES**		**Type of Unit**	**No. of Units**
63	RNA isolation kit		reaction	1
64	Gown	SB027	item	0.5
65	Bleach 10%	SL020	ml	0.75
66	High fidelity hot start Taq polymerase		ul	0.5
67	PCR buffer		ul	10
68	MgCl2		ul	3
69	F Primer		ul	2
70	R Primer		ul	2
71	Ethidium bromide (10 mg/ml)	SL239	ul	5
72	DNA ladder, 100bp		ul	5
73	Loading buffer with dye	SL210	ul	20
74	Agarose ultrapure		g	0.8
75	Agarose NuSieve GTG		g	1.6
76	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	1300
77	Masking tape		inch	12
78	96 Capillary array		item	1/200
79	Cycle sequencing kit		ul	16
80	Cycle sequencing purification plates		each	1
81	Optical 96 well reaction plate		each	1
82	0.2 ml strip tubes		each	3
83	Milli-Q water		ml	35
84	Exonuclease I / Shrimp alkaline phosphatase		ul	2
85	Septa		each	0.3
86	Sequencing cassette		each	1
87	Polymer		ul	1/125
88	15 mL centrifuge tubes	SL241		2
89	50 mL centrifuge tubes			2
90	2 mL plastic tubes		each	1
91	Running buffer		ul	80
92	0.5 mL microcentrifuge tubes			2
93	Extraction tubs		each	4
94	dNTPs		uL	6
95	EDTA		item	6
96	Filter Micropipet Tip, 10uL		item	57
97	Filter Micropipet Tip, 20 uL		item	36
98	Filter Micropipet Tip, 200uL		item	17
99	Formamide	SL192	uL	100
100	Gloves, Nonsterile, Latex	SB022	pair	2.5
101	Gloves, Nonsterile, Nitrile	SB023	pair	0.5
102	Gown, Impervious, staff	SB027	item	0.5
103	Kimwipe	SM027	item	6
104	Micropipet Tip, 1000uL		item	7
105	PCR Grade Water	SL244	uL	204
106	Reverse Transcription Kit		item	6
107	RNase Zap		mL	30
108	Sealing Foil		each	2
109				
110	Transfer Pipet		item	1
111	Extraction tubs		each	4
112	Extraction tip assembly		each	1
113	somatic hypermutation analysis kit		each	1/33
114				
115	**Equipment**			**Time in Use Minutes**
116	Analytical balance		EP004	1
117	Capillary electrophoresis instrument, 96 well - sequencing			12
118	Capillary electrophoresis sequencing software			12
119	Centrifuge		EP059	2
120	Cooling block			2
121	Gel electrophoresis apparatus with power supply		EP063	15
122	Gel imaging system			2
123	Micro-volume spectrophotometer with specimen retention technology			1
124	Nucleic acid extraction instrument			9
125	Nucleic acid workstation			20
126	Pipet set		EP071	30
127				
128	Thermal cycler			13
129	Water bath		EP043	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81265**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *IXXXX6 - 9 were crosswalked to L2XX2*			Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells) (Use IXXX7 in conjunction with IXXX6) Performed on 2 specimens
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**93**
6	*Lab Tech*	*L033A*		*27*
7	*Cytotechnologist*	*L045A*		*66*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**96**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**16.5**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1.5
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	9
15	**DNA Extraction**	L045A	Cytotechnologist	6
16	Extraction (run set up)			
17	Extraction (aliquoting, instrument set up, DNA concentration)			
18	**PCR Set Up -**	L045A	Cytotechnologist	19.5
19	Generate run on computer, generate a run on computer, and prepare tray map			
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)			
21	Retrieve sample, position on tray map			
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix			
23	Aliqout mastermix and sample to well			
24	Vortex and spin sample			
25	Set up Thermocycler and load samples			
26	Remove samples from thermocycler			
27				
28	Prepare Gel			
29	Load Gel			
30	Gel and Label picture			
31	**PCR Post Processing -**	L045A	Cytotechnologist	37.5
32	Post-PCR -Prepare loading master mix			
33	Dilute sample			
34	Denature/cool samples			
35	Load sample onto instrument			
36	**Review sample and prepare data for physician interpretation -**	L045A	Cytotechnologist	3
37	**End: When specimen is ready for examination by physician**			
38	**Service Period**			
39				
40	**End: When specimen is ready for examination by physician**			
41	**Post-Service Period**			
42	**Start: When specimen examination by physician is complete**			
43	Enter results in lab information system after physician interpretation	L033A	Lab Tech	3
44	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	3
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste -	L033A	Lab Tech	3
46	Clean Room -	L033A	Lab Tech	3
47	Perform station maintenance including system rinse and dry -	L033A	Lab Tech	3
48	Perform scheduled data management back-up	L033A	Lab Tech	1.5
49	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81265**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *IXXXX6 - 9 were crosswalked to L2XX2*			Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells) (Use IXXX7 in conjunction with IXXX6) Performed on 2 specimens
3		**CMS Code**	**Staff Type**	**Minutes**
50	**SUPPLIES**		**Type of Unit**	**No. of Units**
51	DNA isolation kit		reaction	1
52	Gown	SB027	item	0.5
53	Gloves, nonsterile	SB022	pair	2.5
54	Bleach 10%	SL020	ml	0.75
55	High fidelity hot start Taq polymerase		ul	0.75
56	PCR buffer		ul	15
57	MgCl2		ul	4.5
58	F Primer, fluorescent		ul	3
59	R Primer, fluorescent		ul	3
60	dNTPs		ul	3
61				
62				
63				
64				
65				
66				
67	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
68	Milli-Q water		ml	40
69	Masking tape		inch	12
70	0.2 mL strip tubes		each	2
71	0.5 mL microcentrifuge tubes			2
72	2 mL plastic tubes		each	2
73	PCR grade water	SL244	ul	228
74	Barrier pipet tips1000 uL		ul	1
75	Barrier pipet tips 200 uL		each	3
76	Barrier pipet tips 20uL		each	10
77	Running buffer		ul	10
78	Formamide	SL192	ul	30
79	Size standard		ul	2.6
80	Optical 96 well reaction plate		each	1
81	Septa		each	0.3
82	Polymer		ul	3:40
83	Capillary array		item	1/200
84	Cassette		each	1
85	Extraction tubs		each	4
86	Extraction tip assembly		each	1
87	**Equipment**			**Time in Use Minutes**
88	Analytical balance		EP004	1
89	Capillary electrophoresis instrument - fragment analysis			15
90	Capillary electrophoresis instrument - fragment analysis software			15
91	Centrifuge		EP059	2
92	Cooling block			1
93				
94				
95	Micro-volume spectrophotometer with specimen retention technology			1
96	Nucleic acid extraction instrument			5
97	Nucleic acid workstation			13
98	Pipet set		EP071	14
99	Thermal cycler			25
100	Water bath		EP043	5

	A	B	C	D	E	F
1	**TAB 5-FINAL RECOMMENDATION**			**81266**	**81267**	**81268**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *IXXXX6 - 9 were crosswalked to L2XX2*			Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure) (Use IXXX7 in conjunction with IXXX6) Batch size 4	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection Batch size 4	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type Batch size 4
3		**CMS Code**	**Staff Type**		**Minutes**	**Minutes**
4	**Global Period**			**(Use IXXX7 in conjunction with IXXX6)**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**62**	**62**	**62**
6	*Lab Tech*	*L033A*		*18*	*18*	*18*
7	*Cytotechnologist*	*L045A*		*44*	*44*	*44*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**51**	**51**	**51**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**					
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**
11	**PRE-SERVICE**					
12	**Start: When preparing containers/requisitions for physician begins**					
13	**Confirm** orders	L033A	Lab Tech	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4	4
16	Extraction (run set up)					
17	Extraction (aliquoting, instrument set up, DNA concentration)					
18	**PCR Set Up**	L045A	Cytotechnologist	13	13	13
19	Generate run on computer, generate a run on computer, and prepare tray map					
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)					
21	Retrieve sample, position on tray map					
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix					
23	Aliqout mastermix and sample to well					
24	Vortex and spin sample					
25	Set up Thermocycler and load samples					
26	Remove samples from thermocycler					
27						
28						
29						
30						
31	**PCR Post Processing**	L045A	Cytotechnologist	25	25	25
32	Post-PCR -Prepare loading master mix					
33	Dilute sample					
34	Denature/cool samples					
35	Load sample onto instrument					
36	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2	2
37	**End: When specimen is ready for examination by physician**					
38	**Service Period**					
39						
40	**End: When specimen is ready for examination by physician**					
41	**Post-Service Period**					
42	**Start: When specimen examination by physician is complete**					
43	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2
44	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2
46	Clean Room	L033A	Lab Tech	2	2	2
47	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2
48	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1
49	**End: When specimen, chemical waste and record handling is complete**					
50	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**	**No. of Units**
51	DNA isolation kit		reaction	1	1	1
52	Gown	SB027	item	0.5	0.5	0.5
53	Gloves, nonsterile	SB022	pair	2.5	2.5	2.5
54	Bleach 10%	SL020	ml	0.75	0.75	0.75
55	High fidelity hot start Taq polymerase		ul	0.75	0.75	0.75
56	PCR buffer		ul	15	15	15
57	MgCl2		ul	4.5	4.5	4.5
58	F Primer, fluorescent		ul	3	3	3
59	R Primer, fluorescent		ul	3	3	3
60	dNTPs		ul	3	3	3
61						
62	Ethidium bromide (10 mg/ml)	SL239	ul	5	5	5

	A	B	C	D	E	F
1	**TAB 5-FINAL RECOMMENDATION**			**81266**	**81267**	**81268**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *IXXXX6 - 9 were crosswalked to L2XX2*			Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure) (Use IXXX7 in conjunction with IXXX6) Batch size 4	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection Batch size 4	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type Batch size 4
3		**CMS Code**	**Staff Type**		**Minutes**	**Minutes**
63	DNA ladder, 100bp		ul	5	5	5
64	Loading buffer with dye	SL210	ul	20	20	20
65	Agarose ultrapure		g	0.8	0.8	0.8
66	Agarose NuSieve GTG		g	1.6	1.6	1.6
67	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100	100
68	Milli-Q water		ml	40	40	40
69	Masking tape		inch	12	12	12
70	0.2 mL strip tubes		each	2	2	2
71	0.5 mL microcentrifuge tubes			2	2	2
72	2 mL plastic tubes		each	2	2	2
73	PCR grade water	SL244	ul	228	228	228
74	Barrier pipet tips1000 uL		ul	1	1	1
75	Barrier pipet tips 200 uL		each	3	3	3
76	Barrier pipet tips 20uL		each	10	10	10
77	Running buffer		ul	10	10	10
78	Formamide	SL192	ul	30	30	30
79	Size standard		ul	2.6	2.6	2.6
80	Optical 96 well reaction plate		each	1	1	1
81	Septa		each	0.3	0.3	0.3
82	Polymer		ul	3:40	3:40	3:40
83	Capillary array		item	1/200	1/200	1/200
84	Cassette		each	1	1	1
85	Extraction tubs		each	4	4	4
86	Extraction tip assembly		each	1	1	1
87	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
88	Analytical balance		EP004	1	1	1
89	Capillary electrophoresis instrument - fragment analysis			15	15	15
90	Capillary electrophoresis instrument - fragment analysis software			15	15	15
91	Centrifuge		EP059	2	2	2
92	Cooling block			1	1	1
93						
94						
95	Micro-volume spectrophotometer with specimen retention technology			1	1	1
96	Nucleic acid extraction instrument			5	5	5
97	Nucleic acid workstation			13	13	13
98	Pipet set		EP071	14	14	14
99	Thermal cycler			25	25	25
100	Water bath		EP043	5	5	5

	A	B	C	D	E	F
1	**TAB 5 - FINAL RECOMMENDATION**			**81292**	**81295**	**81317**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size -* *Crosswalked to L2XXX7 = 2*			MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
3	**---- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**129**	**129**	**129**
6	*Lab Tech*	*L033A*		*18*	*18*	*18*
7	*Cytotechnologist*	*L045A*		*111*	*111*	*111*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**118**	**118**	**118**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**					
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**
11	**PRE-SERVICE**					
12	**Start: When preparing containers/requisitions for physician begins**					
13	**Confirm** orders	L033A	Lab Tech	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4	4
16	**PCR Set-up**	L045A	Cytotechnologist	35	35	35
17	**PCR Gel (***L7: 14products)*	L045A	Cytotechnologist	20	20	20
18	**PCR Post Processing 1**	L045A	Cytotechnologist	30	30	30
19	**Post PCR Processing 2**	L045A	Cytotechnologist	20	20	20
20	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2	2
21	**End: When specimen is ready for examination by physician**					
22	**Service Period**					
23						
24	**Post-Service Period**					
25	**Start: When specimen examination by physician is complete**					
26	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2
27	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2
28	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2
29	Clean Room	L033A	Lab Tech	2	2	2
30	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2
31	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1
32	**End: When specimen, chemical waste and record handling is complete**					
33	**SUPPLIES**		**Type of Unit**			
34	DNA isolation kit		reaction	1	1	1
35	Gown	SB027	item	1	1	1
36	Gloves, nonsterile	SB022	pair	5	5	5
37	Bleach 10%	SL020	ml	1.5	1.5	1.5
38	High fidelity hot start Taq polymerase		ul	7	7	7
39	PCR buffer		ul	140	140	140
40	MgCl2		ul	42	42	42
41	F Primer X 14		ul	2	2	2
42	R Primer X 14		ul	2	2	2
43	dNTPs		ul	28	28	28
44	PCR grade water	SL244	ul	952	952	952
45	Ethidium bromide (10 mg/ml)	SL239	ul	5	5	5
46	DNA ladder, 100bp		ul	5	5	5
47	Loading buffer with dye	SL210	ul	20	20	20
48	Agarose ultrapure		g	0.8	0.8	0.8
49	Agarose NuSieve GTG		g	1.6	1.6	1.6
50	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100	100
51	Masking tape		inch	12	12	12
52	96 Capillary array		item	1/200	1/200	1/200
53	Cycle sequencing kit		ul	224	224	224
54	Cycle sequencing purification plates		each	1	1	1
55	Optical 96 well reaction plate		each	1	1	1
56	Sequencing primers		ul	56	56	56
57	0.2 mL strip tubes		each	4	4	4
58	0.2 ml PCR tubes		each	15	15	15
59	Milli-Q water		ml	35	35	35
60	Exonuclease I / Shrimp alkaline phosphatase		ul	28	28	28
61	Septa		each	0.3	0.3	0.3
62	Sequencing cassette		each	1	1	1
63	Polymer		ul	14/125	14/125	14/125
64	Formamide	SL192	ul	420	420	420
65	15 mL centrifuge tubes	SL241		2	2	2
66	50 mL centrifuge tubes			2	2	2
67	2 mL plastic tubes		each	14	14	14
68	Running buffer		ul	80	80	80
69	0.5 mL microcentrifuge tubes			25	25	25
70	Barrier pipet tips1000 uL		ul	4	4	4

	A	B	C	D	E	F
1	**TAB 5 - FINAL RECOMMENDATION**			**81292**	**81295**	**81317**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size -* *Crosswalked to L2XXX7 = 2*			MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
3	**---- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
71	Barrier pipet tips 200 uL		each	32	32	32
72	Barrier pipet tips 20uL		each	200	200	200
73	Extraction tubs		each	4	4	4
74	Extraction tip assembly		each	1	1	1
75						
76	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
77	Analytical balance		EP004	1	1	1
78	Capillary electrophoresis instrument - sequencing			36	36	36
79	Capillary electrophoresis sequencing software			36	36	36
80	Centrifuge		EP059	3	3	3
81	Cooling block			3	3	3
82	Gel electrophoresis apparatus with power supply		EP063	15	15	15
83	Gel imaging system			4	4	4
84	Micro-volume spectrophotometer with specimen retention technology			1	1	1
85	Nucleic acid extraction instrument			5	5	5
86	Nucleic acid workstation			35	35	35
87	Pipet set		EP071	40	40	40
88	Thermal cycler			89	89	89
89	Water bath		EP043	5	5	5

	A	B	C	D	E	F	G	H
1	**TAB 5 - FINAL RECOMMENDATION**			**81293**	**81296**	**81299**	**81303**	**81318**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Crosswalk to 88XX8** *Typical Batch Size - 2*			MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variants	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**	**109**	**109**	**109**
6	*Lab Tech*			*18*	*18*	*18*	*18*	*18*
7	*Cytotechnologist*			*91*	*91*	*91*	*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**	**98**	**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**							
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**	**11**	**11**
11	**PRE-SERVICE**							
12	**Start: When preparing containers/requisitions for physician begins**							
13	**Confirm** orders	L033A	Lab Tech	1	1	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6	6	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4	4	4	4
16	Sort and rack specimen according to test requested							
17	Place blood sample on rocker							
18	Place tips and microtiter plate on liquid handling system 1							
19	Remove cap from blood tube							
20	Place blood sample in liquid handling system 1 rack and allow instrument to read bar code and aliquot blot into microtiter plate							
21	Create plate map for testing and IT interface							
22	Cap blood tube and return specimen to refrigerator until testing completed							
23	Place tips, reagents and microtiter plates on DNA extraction instrument							
24	Place microtiter plate with blood sample on DNA extraction instrument							
25	Discard DNA extraction waste (liquids and solids)							
26	**PCR Set Up**			13	13	13	13	13
27	Assemble PCR Primers, buffer, etc… into plates							
28	Combine reagents for PCR master mix							
29	Place tips, PCR reagents and PCR reaction plate on liquid handling instrument 2							
30	Remove extracted DNA from DNA extraction instrument and place on liquid handling system 2							
31	Allow instrument to set up PCR reaction							
32	Cover plate with sealing mat							
33	Place PCR reaction plate in thermal cycler, enter PCR program, and allow instrument to perform PCR							
34	Discard liquid handling system 2 tips from PCR set up							
35	**Check gel**	L045A	Cytotechnologist	13	13	13	13	13
36	Spin down PCR plate							
37	Mix, heat, cool and pour ethidium bromide containing agarose gel							
38	Combine 8uL of PCR product with 2uL of loading buffer							
39	Add samples, controls and ladder to agarose gel							
40	Photograph gel							
41	Save image and annotate							

	A	B	C	D	E	F	G	H
1	**TAB 5 - FINAL RECOMMENDATION**			**81293**	**81296**	**81299**	**81303**	**81318**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Crosswalk to 88XX8** *Typical Batch Size - 2*			MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variants	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**	**109**	**109**	**109**
6	*Lab Tech*			*18*	*18*	*18*	*18*	*18*
7	*Cytotechnologist*			*91*	*91*	*91*	*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**	**98**	**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**							
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**	**11**	**11**
42	**PCR Post Processing 1**	L045A	Cytotechnologist	17	17	17	17	17
43	Prepare EXO/SAP mix							
44	Add mix to PCR products on plate							
45	Place on thermal cycler							
46	**Dye Term Cycle**	L045A	Cytotechnologist	13	13	13	13	13
47	Prepare sequencing plates							
48	Prepare sequencing Big Dye master mix							
49	Aliquot Big Dye master mix							
50	Add template							
51	Seal, vortex, spin							
52	Place on thermal cycler							
53	**Dye Term Purification**	L045A	Cytotechnologist	24	24	24	24	24
54	Make fresh Sodium Acetate/ETOH							
55	Add to sequencing samples							
56	Spin down for 20 min							
57	Invert plate on towels							
58	Quick spin plate							
59	Make fresh 70% ETOH							
60	Add ETOH to wells							
61	Spin for 5 min							
62	Quick spin plate							
63	Add formamide and sequencing standard							
64	Cover with septa and quick spin							
65	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure “OUT” stack is empty							
66	**Sequencing**	L045A	Cytotechnologist	5	5	5	5	5
67	Load plate onto sequencer							
68	Create new sample sheet using batch name/sample number							
69	Check capillary array after run is completed							
70	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2	2	2	2
71	**End: When specimen is ready for examination by physician**							
72	**Service Period**							
73								
74	**Post-Service Period**							
75	**Start: When specimen examination by physician is complete**							
76	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2	2	2

	A	B	C	D	E	F	G	H
1	**TAB 5 - FINAL RECOMMENDATION**			**81293**	**81296**	**81299**	**81303**	**81318**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Crosswalk to 88XX8** *Typical Batch Size - 2*			MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variants	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**	**109**	**109**	**109**
6	*Lab Tech*			*18*	*18*	*18*	*18*	*18*
7	*Cytotechnologist*			*91*	*91*	*91*	*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**	**98**	**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**							
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**	**11**	**11**
77	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2	2	2
78	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2	2	2
79	Clean Room	L033A	Lab Tech	2	2	2	2	2
80	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2	2	2
81	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1	1	1
82	**End: When specimen, chemical waste and record handling is complete**							
83	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**	**No. of Units**	**No. of Units**	**No. of Units**
84	DNA isolation kit		reaction	1	1	1	1	1
85	Gown	SB027	item	1	1	1	1	1
86	Gloves, nonsterile	SB022	pair	5	5	5	5	5
87	Bleach 10%	SL020	ml	1.5	1.5	1.5	1.5	1.5
88	High fidelity hot start Taq polymerase		ul	0.5	0.5	0.5	0.5	0.5
89	PCR buffer		ul	10	10	10	10	10
90	MgCl2		ul	3	3	3	3	3
91	F Primer		ul	2	2	2	2	2
92	R Primer		ul	2	2	2	2	2
93	dNTPs		ul	2	2	2	2	2
94	PCR grade water	SL244	ul	68	68	68	68	68
95	Ethidium bromide (10 mg/ml)	SL239	ul	5	5	5	5	5
96	DNA ladder, 100bp		ul	5	5	5	5	5
97	Loading buffer with dye	SL210	ul	20	20	20	20	20
98	Agarose ultrapure		g	0.8	0.8	0.8	0.8	0.8
99	Agarose NuSieve GTG		g	1.6	1.6	1.6	1.6	1.6
100	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100	100	100	100
101	Masking tape		inch	12	12	12	12	12
102	96 Capillary array		item	1/200	1/200	1/200	1/200	1/200
103	Cycle sequencing kit		ul	16	16	16	16	16
104	Cycle sequencing purification plates		each	1	1	1	1	1
105	Optical 96 well reaction plate		each	1	1	1	1	1
106	Sequencing primers		ul	4	4	4	4	4
107	0.2 ml strip tubes		each	1	1	1	1	1
108	0.2 ml PCR tubes		each	2	2	2	2	2
109	Barrier pipet tips1000 uL		ul	1	1	1	1	1
110	Barrier pipet tips 200 uL		each	3	3	3	3	3
111	Barrier pipet tips 20uL		each	15	15	15	15	15
112	Milli-Q water		ml	35	35	35	35	35

	A	B	C	D	E	F	G	H
1	**TAB 5 - FINAL RECOMMENDATION**			**81293**	**81296**	**81299**	**81303**	**81318**
2	**Meeting Date: September 2011** **Specialty: Pathology** **Crosswalk to 88XX8** *Typical Batch Size - 2*			MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variants	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
3	**----- DIRECT CROSSWALK**	**CMS Code**	**Staff Type**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**	**Total Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**	**109**	**109**	**109**	**109**
6	*Lab Tech*			*18*	*18*	*18*	*18*	*18*
7	*Cytotechnologist*			*91*	*91*	*91*	*91*	*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**	**98**	**98**	**98**	**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**							
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**	**11**	**11**
113	Exonuclease 1 / Shrimp alkaline phosphatase		ul	4	4	4	4	4
114	Formamide	SL192	ul	30	30	30	30	30
115	Septa		each	0.3	0.3	0.3	0.3	0.3
116	Polymer		ul	1/125	1/125	1/125	1/125	1/125
117	Sequencing cassette		each	1	1	1	1	1
118	Running buffer		ul	80	80	80	80	80
119	15 mL centrifuge tubes	SL241		2	2	2	2	2
120	50 mL centrifuge tubes			2	2	2	2	2
121	2 mL plastic tubes		each	1	1	1	1	1
122	0.5 mL microcentrifuge tubes			2	2	2	2	2
123	Extraction tubs		each	4	4	4	4	4
124	Extraction tip assembly		each	1	1	1	1	1
125								
126	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
127	Analytical balance		EP004	1	1	1	1	1
128	Capillary electrophoresis instrument, 96 well - sequencing			12	12	12	12	12
129	Centrifuge		EP059	3	3	3	3	3
130	Cooling block			3	3	3	3	3
131	Gel electrophoresis apparatus with power supply		EP063	15	15	15	15	15
132	Gel imaging system			4	4	4	4	4
133	Micro-volume spectrophotometer with specimen retention technology			1	1	1	1	1
134	Nucleic acid extraction instrument			5	5	5	5	5
135	Nucleic acid workstation			13	13	13	13	13
136	Pipet set		EP071	20	20	20	20	20
137	Thermal cycler			50	50	50	50	50
138	Water bath		EP043	10	10	10	10	10
139								
140								

	A	B	C	D	E	F
1	**TAB 5 - FINAL RECOMMENDATION**			**81294**	**81297**	**81319**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size = 2* *All crosswalked to L2XXX6*			*MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants Batch 2*	*MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants Batch 2*	*PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants Batch 2*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**118**	**118**	**118**
6	*Lab Tech*	*L033A*		*18*	*18*	*18*
7	*Cytotechnologist*	*L045A*		*100*	*100*	*100*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**107**	**107**	**107**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**					
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**	**11**
11	**PRE-SERVICE**					
12	**Start: When preparing containers/requisitions for physician begins**					
13	**Confirm** orders	L033A	Lab Tech	1	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4	4
16	**PCR Set-up**	L045A	Cytotechnologist	27	27	27
17	**PCR Gel** *(L6: 8products)*	L045A	Cytotechnologist	17	17	17
18	**PCR Post Processing 1**	L045A	Cytotechnologist	20	20	20
19	**Post PCR Processing 2**	L045A	Cytotechnologist	15	15	15
20	**Post PCR Processing 3**	L045A	Cytotechnologist	15	15	15
21	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2	2
22	**End: When specimen is ready for examination by physician**					
23	**Service Period**					
24						
25	**Post-Service Period**					
26	**Start: When specimen examination by physician is complete**					
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2
30	Clean Room	L033A	Lab Tech	2	2	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1
33	**End: When specimen, chemical waste and record handling is complete**					
34	**SUPPLIES**		**Type of Unit**			
35	DNA isolation kit		reaction	1	1	1
36	Gown	SB027	item	1	1	1
37	Gloves, nonsterile	SB022	pair	5	5	5
38	Bleach 10%	SL020	ml	1.5	1.5	1.5
39	High fidelity hot start Taq polymerase		ul	4	4	4
40	PCR buffer		ul	80	80	80
41	MgCl2		ul	24	24	24
42	F Primer X 8		ul	2	2	2
43	R Primer X 8		ul	2	2	2
44	dNTPs		ul	16	16	16
45	PCR grade water	SL244	ul	544	544	544
46	Ethidium bromide (10 mg/ml)	SL239	ul	5	5	5
47	DNA ladder, 100bp		ul	5	5	5
48	Loading buffer with dye	SL210	ul	20	20	20
49	Agarose ultrapure		g	0.8	0.8	0.8
50	Agarose NuSieve GTG		g	1.6	1.6	1.6
51	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100	100
52	Masking tape		inch	12	12	12
53	96 Capillary array		item	1/200	1/200	1/200
54						
55						
56	Optical 96 well reaction plate		each	1	1	1
57						
58	0.2 mL strip tubes		each	2	2	2
59	0.2 ml PCR tubes		each	9	9	9
60	Milli-Q water		ml	35	35	35
61						
62	Septa		each	0.3	0.3	0.3
63						

	A	B	C	D	E	F
1	**TAB 5 - FINAL RECOMMENDATION**			**81294**	**81297**	**81319**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size = 2* *All crosswalked to L2XXX6*			*MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants Batch 2*	*MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants Batch 2*	*PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants Batch 2*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**	**Minutes**
64	Polymer		ul	8/125	8/125	8/125
65	Formamide	SL192	ul	240	240	240
66	15 mL centrifuge tubes	SL241		2	2	2
67	50 mL centrifuge tubes			2	2	2
68	2 mL plastic tubes		each	8	8	8
69	Running buffer		ul	80	80	80
70	0.5 mL microcentrifuge tubes			12	12	12
71	Barrier pipet tips1000 uL		ul	2	2	2
72	Barrier pipet tips 200 uL		each	18	18	18
73	Barrier pipet tips 20uL		each	120	120	120
74	Extraction tubs		each	4	4	4
75	Extraction tip assembly		each	1	1	1
76						
77						
78	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**	**Time in Use Minutes**
79	Analytical balance		EP004	1	1	1
80	Capillary electrophoresis instrument, 96 well - MLPA/Fragment			24	24	24
81	Capillary electrophoresis MLPA/Fragment software			24	24	24
82	Centrifuge		EP059	3	3	3
83	Cooling block			3	3	3
84	Gel electrophoresis apparatus with power supply		EP063	15	15	15
85	Gel imaging system			4	4	4
86	Micro-volume spectrophotometer with specimen retention technology			1	1	1
87	Nucleic acid extraction instrument			5	5	5
88	Nucleic acid workstation			27	27	27
89	Pipet set		EP071	32	32	32
90	Thermal cycler			76	76	76
91	Water bath		EP043	5	5	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81298**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size =2* *All crosswalked to L2XXX6*			*MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis*
3	**--- DIRECT CROSSWALK -**	**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**118**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*100*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**107**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotech	4
16	**PCR Set-up**	L045A	Cytotech	27
17	**PCR Gel** *(L6: 8products)*	L045A	Cytotech	17
18	**PCR Post Processing 1**	L045A	Cytotech	20
19	**Post PCR Processing 2**	L045A	Cytotech	15
20	**Post PCR Processing 3**	L045A	Cytotech	15
21	**Review sample and prepare data for physician interpretation**	L045A	Cytotech	2
22	**End: When specimen is ready for examination by physician**			
23	**Service Period**			
24				
25	**Post-Service Period**			
26	**Start: When specimen examination by physician is complete**			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	**End: When specimen, chemical waste and record handling is complete**			
34				
35	**SUPPLIES**		**Type of Unit**	
36	DNA isolation kit		reaction	1
37	Gown	SB027	item	1
38	Gloves, nonsterile	SB022	pair	5
39	Bleach 10%	SL020	ml	1.5
40	High fidelity hot start Taq polymerase		ul	4
41	PCR buffer		ul	80
42	MgCl2		ul	24
43	F Primer X 8		ul	2
44	R Primer X 8		ul	2
45	dNTPs		ul	16
46	PCR grade water	SL244	ul	544
47	Ethidium bromide (10 mg/ml)	SL239	ul	5
48	DNA ladder, 100bp		ul	5
49	Loading buffer with dye	SL210	ul	20
50	Agarose ultrapure		g	0.8
51	Agarose NuSieve GTG		g	1.6
52	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
53	Masking tape		inch	12
54	96 Capillary array		item	1/200
55	Cycle sequencing kit		ul	128
56	Cycle sequencing purification plates		each	1
57	Optical 96 well reaction plate		each	1
58	Sequencing primers		ul	32
59	0.2 mL strip tubes		each	2
60	0.2 ml PCR tubes		each	9
61	Milli-Q water		ml	35
62	Exonuclease I / Shrimp alkaline phosphatase		ul	16
63	Septa		each	0.3

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81298**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size =2* *All crosswalked to L2XXX6*			*MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis*
3	**--- DIRECT CROSSWALK -**	**CMS Code**	**Staff Type**	**Minutes**
64	Sequencing cassette		each	1
65	Polymer		ul	8/125
66	Formamide	SL192	ul	240
67	15 mL centrifuge tubes	SL241		2
68	50 mL centrifuge tubes			2
69	2 mL plastic tubes		each	8
70	Running buffer		ul	80
71	0.5 mL microcentrifuge tubes			12
72	Barrier pipet tips1000 uL		ul	2
73	Barrier pipet tips 200 uL		each	18
74	Barrier pipet tips 20uL		each	120
75	Extraction tubs		each	4
76	Extraction tip assembly		each	1
77	**Equipment**			**Time in Use Minutes**
78	Analytical balance		EP004	1
79	Capillary electrophoresis instrument, 96 well - sequencing			24
80	Capillary electrophoresis sequencing software			24
81	Centrifuge		EP059	3
82	Cooling block			3
83	Gel electrophoresis apparatus with power supply		EP063	15
84	Gel imaging system			4
85	Micro-volume spectrophotometer with specimen retention technology			1
86	Nucleic acid extraction instrument			5
87	Nucleic acid workstation			27
88	Pipet set		EP071	32
89	Thermal cycler			76
90	Water bath		EP043	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81300**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size =2* *Crosswalked to L2XXX5*			MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis;duplication /deletion variants
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set-up**	L045A	Cytotechnologist	25
17	**PCR Gel** *(L5: 4products)*	L045A	Cytotechnologist	15
18	**PCR Post Processing**	L045A	Cytotechnologist	45
19	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
20	**End: When specimen is ready for examination by physician**			
21	**Service Period**			
22				
23	**Post-Service Period**			
24	**Start: When specimen examination by physician is complete**			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	**End: When specimen, chemical waste and record handling is complete**			
32				
33	**SUPPLIES**		**Type of Unit**	**No. of Units**
34	DNA isolation kit		reaction	1
35	Gown	SB027	item	1
36	Gloves, nonsterile	SB022	pair	5
37	Bleach 10%	SL020	ml	1.5
38	High fidelity hot start Taq polymerase		ul	2
39	PCR buffer		ul	40
40	MgCl2		ul	12
41	F Primer X 4		ul	2
42	R Primer X 4		ul	2
43	dNTPs		ul	8
44	PCR grade water	SL244	ul	272
45	Ethidium bromide (10 mg/ml)	SL239	ul	5
46	DNA ladder, 100bp		ul	5
47	Loading buffer with dye	SL210	ul	20
48	Agarose ultrapure		g	0.8
49	Agarose NuSieve GTG		g	1.6
50	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
51	Masking tape		inch	12
52	96 Capillary array		item	1/200
53				
54				
55	Optical 96 well reaction plate		each	1
56				
57	0.2 mL strip tubes		each	1

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81300**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size =2* *Crosswalked to L2XXX5*			MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis;duplication /deletion variants
3		**CMS Code**	**Staff Type**	**Minutes**
58	0.2 ml PCR tubes		each	5
59	Milli-Q water		ml	35
60				
61	Septa		each	0.3
62				
63	Polymer		ul	4/125
64	Formamide	SL192	ul	120
65	15 mL centrifuge tubes	SL241		2
66	50 mL centrifuge tubes			2
67	2 mL plastic tubes		each	4
68	Running buffer		ul	80
69	0.5 mL microcentrifuge tubes			6
70	Barrier pipet tips1000 uL		ul	1
71	Barrier pipet tips 200 uL		each	9
72	Barrier pipet tips 20uL		each	60
73	Extraction tubs		each	4
74	Extraction tip assembly		each	1
75	Size standard		ul	2.6
76	**Equipment**			**Time in Use Minutes**
77	Analytical balance		EP004	1
78	Capillary electrophoresis instrument, 96 well			12
79	Capillary electrophoresis fragment analysis software			12
80	Centrifuge		EP059	3
81	Cooling block			3
82	Gel electrophoresis apparatus with power supply		EP063	15
83	Gel imaging system			4
84	Micro-volume spectrophotometer with specimen retention technology			1
85	Nucleic acid extraction instrument			5
86	Nucleic acid workstation			25
87	Pipet set		EP071	30
88	Thermal cycler			63
89	Water bath		EP043	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81301**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *crosswalked to L2XX2*			Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed Performed on 2 specimens
3	**ADJUSTED FOR PERFORMING PROCEDURE ON 2 SPECIMEN**	**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**115.5**
6	*Lab Tech*	*L033A*		*27*
7	*Cytotechnologist*	*L045A*		*89*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**99**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**16.5**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders -	L033A	Lab Tech	1.5
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	9
15	**DNA Extraction -**	L045A	Cytotechnologist	9
16	Extraction (run set up)			
17	Extraction (aliquoting, instrument set up, DNA concentration)			
18	**PCR Set Up -**	L045A	Cytotechnologist	19.5
19	Generate run on computer, generate a run on computer, and prepare tray map			
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)			
21	Retrieve sample, position on tray map			
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix			
23	Aliqout mastermix and sample to well			
24	Vortex and spin sample			
25	Set up Thermocycler and load samples			
26	Remove samples from thermocycler			
27	**PCR Gel -**	L045A	Cytotechnologist	19.5
28	Prepare Gel			
29	Load Gel			
30	Gel and Label picture			
31	**PCR Post Processing -**	L045A	Cytotechnologist	37.5
32	Post-PCR -Prepare loading master mix			
33	Dilute sample			
34	Denature/cool samples			
35	Load sample onto instrument			
36	**Review sample and prepare data for physician interpretation -**	L045A	Cytotechnologist	3
37	**End: When specimen is ready for examination by physician**			
38	**Service Period**			
39				
40	**End: When specimen is ready for examination by physician**			
41	**Post-Service Period**			
42	**Start: When specimen examination by physician is complete**			
43	Enter results in lab information system after physician interpretation-	L033A	Lab Tech	3
44	Prepare, pack and transport specimens and records for in-house storage and external storage-	L033A	Lab Tech	3
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste - added 1 minute	L033A	Lab Tech	3
46	Clean Room-	L033A	Lab Tech	3
47	Perform station maintenance including system rinse and dry -	L033A	Lab Tech	3

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81301**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *crosswalked to L2XX2*			Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed Performed on 2 specimens
48	Perform scheduled data management back-up -	L033A	Lab Tech	1.5
49	**End: When specimen, chemical waste and record handling is complete**			
50	**SUPPLIES**		**Type of Unit**	**No. of Units**
51	DNA isolation kit		reaction	1
52	Gown	SB027	item	0.5
53	Gloves, nonsterile	SB022	pair	2.5
54	Bleach 10%	SL020	ml	0.75
55	High fidelity hot start Taq polymerase		ul	3
56	MSI primer, reagent kit		ul	2/100 kit
57				
58				
59				
60				
61				
62	Ethidium bromide (10 mg/ml)	SL239	ul	5
63	DNA ladder, 100bp		ul	5
64	Loading buffer with dye	SL210	ul	20
65	Agarose ultrapure		g	0.8
66	Agarose NuSieve GTG		g	1.6
67	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
68	Milli-Q water		ml	40
69	Masking tape		inch	12
70	0.2 mL strip tubes		each	2
71	0.5 mL microcentrifuge tubes			2
72	2 mL plastic tubes		each	2
73	PCR grade water	SL244	ul	228
74	Barrier pipet tips1000 uL		ul	1
75	Barrier pipet tips 200 uL		each	3
76	Barrier pipet tips 20uL		each	10
77	Running buffer		ul	10
78	Formamide	SL192	ul	30
79	Size standard		ul	2.6
80	Optical 96 well reaction plate		each	1
81	Septa		each	0.3
82	Polymer		ul	3:40
83	Capillary array		item	1/200
84	Cassette		each	1
85	Extraction tubs		each	4
86	Extraction tip assembly		each	1
87				
88	**Equipment**			**Time in Use Minutes**
89	Analytical balance		EP004	1
90	Capillary electrophoresis instrument - fragment analysis			15
91	Capillary electrophoresis instrument - fragment analysis software			15
92	Centrifuge		EP059	2
93	Cooling block			1
94	Gel electrophoresis apparatus with power supply		EP063	8
95	Gel imaging system			2
96	Micro-volume spectrophotometer with specimen retention technology			1
97	Nucleic acid extraction instrument			5
98	Nucleic acid workstation			13

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81301**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4* *crosswalked to L2XX2*			Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed Performed on 2 specimens
99	Pipet set		EP071	14
100	Thermal cycler			25
101	Water bath		EP043	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81302**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size - 2* *REFERENCED CODE = L2XXX5*			*MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; full sequence analysis
3	----- DIRECT CROSSWALK --	**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**109**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*91*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**98**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set-up**	L045A	Cytotechnologist	25
17	**PCR Gel** *(L5: 4products)*	L045A	Cytotechnologist	15
18	**PCR Post Processing**	L045A	Cytotechnologist	45
19	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
20	**End: When specimen is ready for examination by physician**			
21	**Service Period**			
22				
23	**Post-Service Period**			
24	**Start: When specimen examination by physician is complete**			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	**End: When specimen, chemical waste and record handling is complete**			
32	**SUPPLIES**		**Type of Unit**	**No. of Units**
33	DNA isolation kit		reaction	1
34	Gown	SB027	item	1
35	Gloves, nonsterile	SB022	pair	5
36	Bleach 10%	SL020	ml	1.5
37	High fidelity hot start Taq polymerase		ul	2
38	PCR buffer		ul	40
39	MgCl2		ul	12
40	F Primer X 4		ul	2
41	R Primer X 4		ul	2
42	dNTPs		ul	8
43	PCR grade water	SL244	ul	272
44	Ethidium bromide (10 mg/ml)	SL239	ul	5
45	DNA ladder, 100bp		ul	5
46	Loading buffer with dye	SL210	ul	20
47	Agarose ultrapure		g	0.8
48	Agarose NuSieve GTG		g	1.6
49	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
50	Masking tape		inch	12
51	96 Capillary array		item	1/200
52	Cycle sequencing kit		ul	64
53	Cycle sequencing purification plates		each	1
54	Optical 96 well reaction plate		each	1
55	Sequencing primers		ul	16

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81302**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size - 2* *REFERENCED CODE = L2XXX5*			*MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; full sequence analysis
3	----- DIRECT CROSSWALK --	**CMS Code**	**Staff Type**	**Minutes**
56	0.2 mL strip tubes		each	1
57	0.2 ml PCR tubes		each	5
58	Milli-Q water		ml	35
59	Exonuclease I / Shrimp alkaline phosphatase		ul	8
60	Septa		each	0.3
61	Sequencing cassette		each	1
62	Polymer		ul	4/125
63	Formamide	SL192	ul	120
64	15 mL centrifuge tubes	SL241		2
65	50 mL centrifuge tubes			2
66	2 mL plastic tubes		each	4
67	Running buffer		ul	80
68	0.5 mL microcentrifuge tubes			6
69	Barrier pipet tips1000 uL		ul	1
70	Barrier pipet tips 200 uL		each	9
71	Barrier pipet tips 20uL		each	60
72	Extraction tubs		each	4
73	Extraction tip assembly		each	1
74				
75	**Equipment**			**Time in Use Minutes**
76	Analytical balance		EP004	1
77	Capillary electrophoresis instrument, 96 well - sequencing			12
78	Capillary electrophoresis sequencing software			12
79	Centrifuge		EP059	3
80	Cooling block			3
81	Gel electrophoresis apparatus with power supply		EP063	15
82	Gel imaging system			4
83	Micro-volume spectrophotometer with specimen retention technology			1
84	Nucleic acid extraction instrument			5
85	Nucleic acid workstation			25
86	Pipet set		EP071	30
87	Thermal cycler			63
88	Water bath		EP043	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81304**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size = 2* *Crosswalked to L2XXX5*			*MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; duplication/deletion variants
3		**CMS Code**	**Staff Type**	**XXX**
4	**Global Period**			
5	**TOTAL CLINICAL LABOR TIME**			**88**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*70*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**77**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set-up**	L045A	Cytotechnologist	18.75
17	**PCR Gel** *(L5: 4products)* **-**	L045A	Cytotechnologist	11.25
18	**PCR Post Processing -**	L045A	Cytotechnologist	33.75
19	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
20	**End: When specimen is ready for examination by physician**			
21	**Service Period**			
22				
23	**Post-Service Period**			
24	**Start: When specimen examination by physician is complete**			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	**End: When specimen, chemical waste and record handling is complete**			
32				
33	**SUPPLIES**		**Type of Unit**	**No. of Units**
34	DNA isolation kit		reaction	1
35	Gown	SB027	item	1
36	Gloves, nonsterile	SB022	pair	5
37	Bleach 10%	SL020	ml	1.5
38	High fidelity hot start Taq polymerase		ul	2
39	PCR buffer		ul	40
40	MgCl2		ul	12
41	F Primer X 4		ul	8
42	R Primer X 4		ul	8
43	dNTPs		ul	8
44	PCR grade water	SL244	ul	272
45	Ethidium bromide (10 mg/ml)	SL239	ul	5
46	DNA ladder, 100bp		ul	5
47	Loading buffer with dye	SL210	ul	20
48	Agarose ultrapure		g	0.8
49	Agarose NuSieve GTG		g	1.6
50	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
51	Masking tape		inch	12
52	96 Capillary array		item	1/200
53				
54				
55	Optical 96 well reaction plate		each	1
56				

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81304**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Typical Batch Size = 2* *Crosswalked to L2XXX5*			*MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; duplication/deletion variants
3		**CMS Code**	**Staff Type**	**XXX**
57	0.2 mL strip tubes		each	1
58	0.2 ml PCR tubes		each	5
59	Milli-Q water		ml	35
60				
61	Septa		each	0.3
62				
63	Polymer		ul	4/125
64	Formamide	SL192	ul	120
65	15 mL centrifuge tubes	SL241		2
66	50 mL centrifuge tubes			2
67	2 mL plastic tubes		each	4
68	Running buffer		ul	80
69	0.5 mL microcentrifuge tubes			6
70	Barrier pipet tips1000 uL		ul	1
71	Barrier pipet tips 200 uL		each	9
72	Barrier pipet tips 20uL		each	60
73	Extraction tubs		each	4
74	Extraction tip assembly		each	1
75	Size standard		ul	2.6
76	**Equipment**			**Time in Use Minutes**
77	Analytical balance		EP004	1
78	Capillary electrophoresis instrument, 96 well			12
79	Capillary electrophoresis fragment analysis software			12
80	Centrifuge		EP059	3
81	Cooling block			3
82	Gel electrophoresis apparatus with power supply		EP063	15
83	Gel imaging system			4
84	Micro-volume spectrophotometer with specimen retention technology			1
85	Nucleic acid extraction instrument			5
86	Nucleic acid workstation			25
87	Pipet set		EP071	30
88	Thermal cycler			63
89	Water bath		EP043	5

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81331**	**81257**
2	**Meeting Date: September 2011** **Specialty: Pathology Crosswalk to L2** *Adjusted for Batch Size - 4*			*SNRPN/UBE3A* (*small nuclear ribonucleoprotein polypeptide* N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	*HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
4	**Global Period**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**50**	**50**
6	*Lab Tech*	*L033A*		*18*	*18*
7	*Cytotechnologist*	*L045A*		*32*	*32*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**39**	**39**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**				
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**	**11**
11	**PRE-SERVICE**				
12	**Start: When preparing containers/requisitions for physician begins**				
13	**Confirm** orders	L033A	Lab Tech	1	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	LO45B	Lab Tech	6	6
15	**DNA Extraction**	L045A	Cytotechnologist	4	4
16	Extraction (run set up)				
17	Extraction (aliquoting, instrument set up, DNA concentration)			5 (bisulfite modification)	X
18	**PCR Set Up**	L045A	Cytotechnologist	13	13
19	Generate run on computer, generate a run on computer, and prepare tray map				
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)				
21	Retrieve sample, position on tray map				
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix				
23	Aliqout mastermix and sample to well				
24	Vortex and spin sample				
25	Set up Thermocycler and load samples				
26	Remove samples from thermocycler				
27	**PCR Gel**	L045A	Cytotechnologist	13	13
28	Prepare Gel				
29	Load Gel				
30	Gel and Label picture				
31					
32					
33					
34					

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81331**	**81257**
2	**Meeting Date: September 2011** **Specialty: Pathology Crosswalk to L2** *Adjusted for Batch Size - 4*			*SNRPN/UBE3A* (*small nuclear ribonucleoprotein polypeptide* N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	*HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
35					
36					
37					
38	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2	2
39	**End: When specimen is ready for examination by physician**				
40	**Service Period**				
41					
42	**End: When specimen is ready for examination by physician**				
43	**Post-Service Period**				
44	**Start: When specimen examination by physician is complete**				
45	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
46	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
47	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
48	Clean Room	L033A	Lab Tech	2	2
49	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
50	Perform scheduled data management back-up	L033A	Lab Tech	1	1
51	**End: When specimen, chemical waste and record handling is complete**				
52	**SUPPLIES**		**Type of Unit**	**No. of Units**	**No. of Units**
53	DNA isolation kit		reaction	1	1
54	Gown	SB027	item	0.5	0.5
55	Gloves, nonsterile	SB022	pair	2.5	2.5
56	Bleach 10%	SL020	ml	0.75	0.75
57	High fidelity hot start Taq polymerase		ul	0.75	0.75
58	PCR buffer		ul	15	15
59	MgCl2		ul	4.5	4.5
60					
61					
62	F Primer		ul	3	3
63	R Primer		ul	3	3
64	dNTPs		ul	3	3
65					
66	Ethidium bromide (10 mg/ml)	SL239	ul	5	5
67	DNA ladder, 100bp		ul	5	5
68	Loading buffer with dye	SL210	ul	20	20
69	Agarose ultrapure		g	0.8	0.8
70	Agarose NuSieve GTG		g	1.6	1.6
71	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100	100
72	Milli-Q water		ml	40	40
73	Masking tape		inch	12	12
74	0.2 mL strip tubes		each	2	2
75	0.5 mL microcentrifuge tubes			2	2
76	2 mL plastic tubes		each	2	2
77	PCR grade water	SL244	ul	228	228
78	Barrier pipet tips1000 uL		ul	1	1
79	Barrier pipet tips 200 uL		each	3	3
80	Barrier pipet tips 20uL		each	10	10
81	Cassette		each	1	1
82	Extraction tubs		each	4	4
83	Extraction tip assembly		each	1	1
84					
85					
86					
87					
88					
89					
90					

	A	B	C	D	E
1	**TAB 5 - FINAL RECOMMENDATION**			**81331**	**81257**
2	**Meeting Date: September 2011** **Specialty: Pathology Crosswalk to L2** *Adjusted for Batch Size - 4*			*SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide* N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	*HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)*
3		**CMS Code**	**Staff Type**	**Minutes**	**Minutes**
91					
92	**Equipment**			**Time in Use Minutes**	**Time in Use Minutes**
93	Analytical balance		EP004	1	1
94					
95					
96	Centrifuge		EP059	2	2
97	Cooling block			1	1
98	Gel electrophoresis apparatus with power supply		EP063	8	8
99	Gel imaging system			2	2
100	Micro-volume spectrophotometer with specimen retention technology			1	1
101	Nucleic acid extraction instrument			5	5
102	Nucleic acid workstation			13	13
103	Pipet set		EP071	14	14
104	Thermal cycler			25	25
105	Water bath		EP043	5	5

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81332**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4*			*SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1)* (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)
3		**CMS Code**	**Staff Type**	**Minutes**
4	**Global Period**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**68**
6	*Lab Tech*	*L033A*		*18*
7	*Cytotechnologist*	*L045A*		*50*
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**57**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**11**
11	**PRE-SERVICE**			
12	**Start: When preparing containers/requisitions for physician begins**			
13	**Confirm** orders	L033A	Lab Tech	1
14	**Accession** specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	**DNA Extraction**	L045A	Cytotechnologist	4
16	**PCR Set Up -**	L045A	Cytotechnologist	15
17	Retrieve sample, verify order/position on tray map			
18	Prepare cocktail and add to samples			
19	Set up Thermocycler and load samples			
20	Remove samples from thermocycler			
21	**PCR Gel -**	L045A	Cytotechnologist	20
22	Prepare Gel			
23	Load Gel			
24	Gel and Label picture			
25	**PCR Post Processing -**	L045A	Cytotechnologist	9
26	Prepare and add digest mix			
27	Pulse samples			
28	Set up thermocycler			
29	Load samples on thermocycler			
30	Remove samples from thermocycler			
31	Pulse samples			
32	**Review sample and prepare data for physician interpretation**	L045A	Cytotechnologist	2
33	**End: When specimen is ready for examination by physician**			
34	**Service Period**			
35				
36	**Post-Service Period**			
37	**Start: When specimen examination by physician is complete**			
38	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
39	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
40	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
41	Clean Room	L033A	Lab Tech	2
42	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
43	Perform scheduled data management back-up	L033A	Lab Tech	1
44	**End: When specimen, chemical waste and record handling is complete**			

	A	B	C	D
1	**TAB 5 - FINAL RECOMMENDATION**			**81332**
2	**Meeting Date: September 2011** **Specialty: Pathology** *Adjusted for Batch Size - 4*			*SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1)* (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)
3		**CMS Code**	**Staff Type**	**Minutes**
45	**SUPPLIES**		**Type of Unit**	**No. of Units**
46	DNA isolation kit		reaction	1
47	Gown	SB027	item	0.5
48	Gloves, nonsterile	SB022	pair	2.5
49	Bleach 10%	SL020	ml	1.5
50	High fidelity hot start Taq polymerase -		ul	1
51	PCR buffer -		ul	30
52	MgCl2		ul	9
53	F Primer		ul	6
54	R Primer		ul	6
55	dNTPs		ul	6
56	Taq 1 restriction enzyme		ul	6
57	Agarose ultrapure		g	0.8
58	Agarose NuSieve GTG		g	1.6
59	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
60	Milli-Q water		ml	35
61	Masking tape		inches	12
62	DNA ladder, 100bp		ul	5
63	Loading buffer with dye	SL210	ul	40
64	BSA 100X		ul	6
65	PCR grade water	SL244	ul	204
66	0.2 mL PCR tubes		each	12
67	2 mL plastic tubes		each	4
68	Restriction enzyme buffer		ul	120
69	Milli-Q water		ml	70
70	Extraction tubs		each	4
71	15 mL centrifuge tubes	SL241		4
72	50 mL centrifuge tubes			4
73	Barrier pipet tips 200 uL		item	44
74	Barrier pipet tips 1000 uL		item	4
75	Barrier pipet tips 20 uL		item	55
76	0.5 mL tube		each	3
77	Extraction tip assembly		each	1
78				
79	**Equipment**			**Time in Use Minutes**
80	Analytical balance		EP004	1
81	Centrifuge		EP059	2
82	Cooling block			1
83	Gel electrophoresis apparatus with power supply		EP063	30
84	Gel imaging system			2
85	Micro-volume spectrophotometer with specimen retention technology			1
86	Nucleic acid extraction instrument			5
87	Nucleic acid workstation			10
88	Pipet set		EP071	11
89	Thermal cycler			25
90	Water bath		EP043	270

AMA/Specialty Society RVS Update Committee Summary of Recommendations

September 2011

Molecular Pathology Test-Tier 2

In response to payer requests, the CPT Editorial Panel developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010, the Panel accepted 9 Tier 2 codes, which are a list of codes to be reported when the service is not listed in the Tier 1 codes. The Tier 2 codes are arranged by the level of technical resources and interpretive professional work required. The RUC understands that these services will be rarely reported and represent tests that are established and well developed, however their low volume does not warrant characterization as Tier 1 and unlikely to be automated at this time. If increases, the RUC understands that the test will be assigned a Tier 1 code. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services.

In April 2011, the RUC found it difficult to appropriately assign a physician work valuation to these services. The number of survey respondents for each code ranged from 11 to 26, all below the RUC's required minimum of thirty respondents. The recommendations submitted by the specialty did not reflect appropriate valuation given the corresponding time recommendations. The RUC proposed interim recommendations and the specialty society re-surveyed for the September 2011 RUC Meeting. For the September 2011 RUC meeting, the specialty society was able to garner a significantly higher response rate and thus the RUC has considerable confidence in their survey data for the following Molecular Pathology Tier 2 Tests.

81400 Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)

The RUC reviewed the specialty's survey data from 94 molecular pathologists who provide these services.The survey results indicated a median physician time for 81400 of 10 minutes and a work value of 0.37. The RUC agreed that the median time accurately reflects the amount of time required to perform the service. The RUC compared 81400 to the key reference code 86320 *Immunoelectrophoresis; serum* (work RVU = 0.37) and agreed that the reference code requires more time to perform than the surveyed code, 17 minutes and 10 minutes, respectively The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), and noted that the

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surveyed code requires less time to perform than this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.32, the survey's 25th percentile, for CPT code 81400**.

81401 Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

The RUC reviewed the specialty society's survey data from 59 molecular pathologists who provide these services. The survey data resulted in amedian physician time for 81401 of 15 minutes and a work RVU of 0.50.. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81401 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires more time to perform than the surveyed code, 20 minutes and 15 minutes, respectively. Further, the RUC noted that the key reference code is a more intense service to perform as compared to the reference code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), and noted that the surveyed code requires similar physician time to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.40, the survey's 25th percentile, for CPT code 81401**.

81402 Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)
The RUC reviewed the specialty society's survey data from 61 molecular pathologists who provide these services.that the survey data resulted in a median physician time for 81402 was 20 minutes and a work RVU of 0.52. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81402 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires the same time to provide as compared to the surveyed code, 20 minutes. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), and noted that the surveyed code requires more time to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.50, the survey's 25th percentile, for CPT code 81402**.

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

The RUC reviewed the specialty's society's survey data from 47 molecular pathologists who provide these services, The survey data indicated a median time for 81403 of 28 minutes with a median physician work RVU of 0.77. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81403 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires less time to perform as compared to the surveyed code, 20 minutes and 28 minutes, respectively. However, the specialty acknowledged, and the RUC agreed, that although the surveyed code requires

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more time to perform as compared to the reference code, they are similarly intense services. The RUC also compared this service to 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* (intra-time=30 minutes, work RVU=0.85), and noted that the surveyed code requires less time and is a less intense service to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81403**.

81404 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

The RUC reviewed the specialty society's survey data from 49 molecular pathologist who provide these services. The survey data indicated a median time for 81404 of 30 minutes with a median physician work RVU of 0.83. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81404 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires less time to perform as compared to the surveyed code, 20 minutes and 30 minutes, respectively. Further, the specialty acknowledged ,and the RUC agreed, that the surveyed code is a more intense service to perform in comparison to the reference code. The RUC also compared this service to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU=0.94) and noted that the reference code requires more time to perform in comparison to the surveyed code, 40 minutes and 30 minutes, respectively. **Based on these comparisons, the RUC recommends a work RVU of 0.65, the survey's 25th percentile, for CPT code 81404**.

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

The RUC reviewed the specialty's survey data from 31 molecular pathologists who provide these services, The survey data indicated a median time for 81405 of 30 minutes with a median physician work RVU of 0.94.. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81403 to the key reference code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU = 1.18) and agreed that the reference code requires more time to perform as compared to the surveyed code, 43 minutes and 30 minutes, respectively. The RUC also compared this service to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU=0.94) and noted that the reference code requires more time to perform in comparison to the surveyed code, 40 minutes and 30 minutes, respectively. **Based on these comparisons, the RUC recommends a work RVU of 0.80, the survey's 25th percentile, for CPT code 81405**.

81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81406 was 60 minutes, with a median work RVU of 1.40. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC

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compared 81406 to the key reference code 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU = 1.83) and agreed that the reference code requires similar time to perform as compared to the surveyed code, 56 minutes and 60 minutes, respectively. However, the specialty acknowledged and the RUC agreed that although the surveyed code requires similar time to perform as compared to the reference code, the reference code is a more intense service to perform in comparison to the surveyed code. The RUC also compared this service to 92626 *Evaluation of auditory rehabilitation status; first hour* (intra-time=60 minutes, work RVU=1.40), and noted that the surveyed code requires the same time and is a similarly intense service to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 1.40, the survey's median, for CPT code 81406**.

81407 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81406 was 60 minutes, with a median work RVU of 1.85. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81407 to the key reference code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU = 2.80) and agreed that the reference code requires more time to perform as compared to the surveyed code, 90 minutes and 60 minutes, respectively. The RUC also compared this service to 96118 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report* (Work RVU=1.86) and noted that this reference code requires the same time to perform in comparison to the surveyed code, 60 minutes. **Based on these comparisons, the RUC recommends a work RVU of 1.85, the survey's median percentile, for CPT code 81407**.

81408 Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81408 was 80 minutes, with a median work RVU of 2.80. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81408 to the key reference code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU = 2.80) and agreed that the reference code requires more time to perform as compared to the surveyed code, 90 minutes and 80 minutes, respectively. The RUC also compared this service to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Work RVU=2.50) and noted that this reference code requires the same time to perform in comparison to the surveyed code, 80 minutes. **Based on these comparisons, the RUC recommends a work RVU of 2.35, the survey's 25th percentile, for CPT code 81408**.

Practice Expense

The practice expense inputs for these services were approved at the April 2011 RUC meeting and forwarded to CMS in May 2011.

Work Neutrality

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Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology

The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recom-mendation
Pathology and Laboratory **Molecular Pathology** The following Molecular Pathology Procedure (Tier 2) codes are used to report procedures not listed in the Tier 1 molecular pathology codes (AXXX1-UXXX1). They represent medically useful procedures that are generally performed in lower volumes than Tier 1 procedures (eg, the incidence of the disease being tested is rare). They are arranged by level of technical resources and interpretive work by the physician.. The individual analyses listed under each code (ie, level of procedure) utilize the definitions and coding principles as described in the introduction preceding the Tier 1 molecular pathology codes. The parenthetical examples of methodologies presented near the beginning of each code provide general guidelines used to group procedures for a given level and are not all-inclusive. Use the appropriate molecular pathology procedure level code that includes the specific analyte listed after the code descriptor. If the analyte tested is not listed under one of the Tier 2 codes or is not represented by a Tier 1 code, use the appropriate methodology codes in the 83890-83914 and 88384-88386 series.				

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(e) 81400	AA1	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) *ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD)* (eg, medium chain acyl dehydrogenase deficiency), K304E variant *ACE (angiotensin converting enzyme)* (eg, hereditary blood pressure regulation), insertion/deletion variant *AGTR1 (angiotensin II receptor, type 1)* (eg, essential hypertension), 1166A>C variant *CCR5 (chemokine C-C motif receptor 5)* (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion *DPYD (dihydropyrimidine dehydrogenase)* (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), IVS14+1G>A variant *F2 (coagulation factor 2)* (eg, hereditary hypercoagulability), 1199G>A variant *F5 (coagulation factor V)* (eg, hereditary hypercoagulability), HR2 variant *F7 (coagulation factor VII [serum prothrombin conversion accelerator])* (eg, hereditary hypercoagulability), R353Q variant *FGB (fibrinogen beta chain)* (eg, hereditary ischemic heart disease), -455G>A variant *F13B (coagulation factor XIII, B polypeptide)* (eg, hereditary hypercoagulability), V34L variant Human Platelet Antigen 1 genotyping (HPA-1), *ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa])* (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-1a/b (L33P) Human Platelet Antigen 2 genotyping (HPA-2), *GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba])* (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-2a/b (T145M) Human Platelet Antigen 3 genotyping (HPA-3), *ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb])* (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-3a/b (I843S) Human Platelet Antigen 4 genotyping (HPA-4), *ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa])* (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-4a/b (R143Q) Human Platelet Antigen 5 genotyping (HPA-5), *ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa])* (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-5a/b (K505E) Human Platelet Antigen 6 genotyping (HPA-6w), *ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa])* (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-6a/b (R489Q) Human Platelet Antigen 9 genotyping (HPA-9w), *ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb*	XXX	0.32

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(e) 81401	AA2	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) *ABL (c-abl oncogene 1, receptor tyrosine kinase)* (eg, acquired imatinib resistance), T315I variant *ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD)* (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) *ADRB2 (adrenergic beta-2 receptor surface)* (eg, drug metabolism), common variants (eg, G16R, Q27E) *APOE (apolipoprotein E)* (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) *CBFB/MYH11 (inv(16))* (eg, acute myeloid leukemia), qualitative, and quantitative, if performed *CCND1/~~IgH~~ IGH (BCL1/~~IgH~~ IGH, t[(11;14]d)* (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative, and quantitative, if performed *CYP3A4 (cytochrome P450, family 3, subfamily A, polypeptide 4)* (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) *CYP3A5 (cytochrome P450, family 3, subfamily A, polypeptide 5)* (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6)	XXX	0.40

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(e) 81402	AA3	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon) *CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2)* (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) *ESR1/PGR (receptor 1/progesterone receptor)* ratio (eg, breast cancer) *KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog)* (eg, mastocytosis), common variants (eg, D816V, D816Y, D816F) *MEFV (Mediterranean fever)* (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) *MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR)* (eg, myeloproliferative disorder), common variants (eg, W515A, W515K, W515L, W515R) *TCD@ (T cell antigen receptor, delta)* (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population	XXX	0.50

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(e) 81403	AA4	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) *ABL1 (c-abl oncogene 1, receptor tyrosine kinase)* (eg, acquired imatinib tyrosine kinase inhibitor resistance), variants in the kinase domain *DAZ/SRY (deleted in azoospermia and sex determining region Y)* (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) *GJB1 (gap junction protein, beta 1)* (eg, Charcot-Marie-Tooth X-linked), full gene sequence *JAK2 (Janus kinase 2)* (eg, myeloproliferative disorder), exon 12 sequence and exon 13 sequence, if performed *KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene)* (eg, carcinoma), gene analysis, variant(s) in exon 2 *MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR)* (eg, myeloproliferative disorder), exon 10 sequence *VHL (von Hippel-Lindau tumor suppressor)* (eg, von Hippel-Lindau familial cancer syndrome), duplication/deletion analysis *VWF (von Willebrand factor)* (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)	XXX	0.52

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(e) 81404	AA5	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) *BTD (biotinidase)* (eg, biotinidase deficiency), full gene sequence *CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1)* (eg, primary congenital glaucoma), full gene sequence *DMPK (dystrophia myotonica-protein kinase)* (eg, myotonic dystrophy type 1), characterization of abnormal (eg, expanded) alleles *EGR2 (early growth response 2)* (eg, Charcot-Marie-Tooth), full gene sequence *FKRP (Fukutin related protein)* (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence *FOXG1 (forkhead box G1)* (eg, Rett syndrome), full gene sequence *FSHMD1A (facioscapulohumeral muscular dystrophy 1A)* (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles	XXX	0.65

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(e) 81405	AA6	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) *CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2)* (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence *FKTN (Fukutin)* (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence *MPZ (myelin protein zero)* (eg, Charcot-Marie-Tooth), full gene sequence *NEFL (neurofilament, light polypeptide)* (eg, Charcot-Marie-Tooth), full gene sequence *RET (ret proto-oncogene)* (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) *SDHB (succinate dehydrogenase complex, subunit B, iron sulfur)* (eg, hereditary paraganglioma), full gene sequence *TGFBR1 (transforming growth factor, beta receptor 1)* (eg, Marfan syndrome), full gene sequence *TGFBR2 (transforming growth factor, beta receptor 2)* (eg, Marfan syndrome), full gene sequence	XXX	0.80

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(e) 81406	AA7	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) *CAPN3 (Calpain 3)* (eg, limb-girdle muscular dystrophy [LGMD] type 2A, alpainopathy), full gene sequence Cytogenomic microarray analysis, neoplasia (eg, interrogation of copy number, and loss-of-heterozygosity via single nucleotide polymorphism [SNP]-based comparative genomic hybridization [CGH] microarray analysis) *GALT* (*galactose-1-phosphate uridylyltransferase*) (eg, galactosemia), full gene sequence *HEXA (hexosaminidase A, alpha polypeptide)* (eg, Tay-Sachs disease), full gene sequence *LMNA (lamin A/C)* (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence *PAH (phenylalanine hydroxylase)* (eg phenylketonuria), full gene sequence *POLG (polymerase [DNA directed], gamma)* (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence	XXX	1.40
● 81407	AA8	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized ~~epilepsy,~~ epilepsy with febrile seizures), full gene sequence	XXX	1.85

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● 81408	AA9	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), full gene sequence VFW (Von Willebrand factor) (Eg, malignant hypertermia), full gene sequence	XXX	2.35

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CAP/ACMG Rec Summary

ISSUE: Molecular Pathology Tier 2

TAB: 6

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	TOTAL-TIME MIN	TOTAL-TIME 25th	TOTAL-TIME MED	TOTAL-TIME 75th	TOTAL-TIME MAX
REF	86320	Physician interpret of immunoelectrophoresis; serum		0.022			0.37			17			17		
SVY	81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)	94	0.037	0.13	0.32	0.37	0.52	1.83		3	7	10	20	30
REC				0.032			0.32			10			10		

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	TOTAL-TIME MIN	TOTAL-TIME 25th	TOTAL-TIME MED	TOTAL-TIME 75th	TOTAL-TIME MAX
REF	88291	Cytogenetics and molecular cytogenetics, interpretation and report		0.026			0.52			20			20		
SVY	81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)	59	0.033	0.25	0.40	0.50	0.68	1.90		5	10	15	22	60
REC				0.027			0.40						15		

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	Total-TIME MIN	Total-TIME 25th	Total-TIME MED	Total-TIME 75th	Total-TIME MAX
REF	88291	Cytogenetics and molecular cytogenetics, interpretation and report		0.026			0.52			20			20		
SVY	81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)	61	0.026	0.25	0.50	0.52	0.87	2.50		5	15	20	30	50
REC				0.025			0.50						20		

CAP/ACMG Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
7						RVW					Total		TOTAL-TIME				
8	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
24																	
25						RVW					Total		Total-TIME				
26	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
27	REF	88291	Cytogenetics and molecular cytogenetics, interpretation and report		0.026			0.52			20				20		
28	SVY	81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	47	0.028	0.40	0.52	0.77	1.00	2.50			10	20	28	35	60
29	REC				0.019			0.52							28		
30																	
31						RVW					Total		Total-TIME				
32	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
33	REF	88291	Cytogenetics and molecular cytogenetics, interpretation and report		0.026			0.52			20				20		
34	SVY	81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	49	0.028	0.50	0.65	0.83	1.15	2.80			7	20	30	45	60
35	REC				0.022			0.65							30		
36																	
37						RVW					Total		Total-TIME				
38	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
39	REF	88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal		0.027			1.18			43				43		
40	SVY	81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)	31	0.031	0.52	0.80	0.94	1.40	4.50			10	20	30	60	80
41	REC				0.027			0.80							30		

CAP/ACMG Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
7						RVW					Total		TOTAL-TIME				
8	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
42																	
43						RVW					Total		total-TIME				
44	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
45	REF	88323	Consult & report on referred material require prep of slides		0.033			1.83			56				56		
46	SVY	81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	27	0.023	0.70	1.00	1.40	1.84	2.80			15	38	60	83	120
47	REC				0.023			1.40							60		
48																	
49						RVW					Total		total-TIME				
50	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
51	REF	88309	Level VI - Surgical pathology, gross and microscopic examination		0.031			2.80			90				90		
52	SVY	81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)	15	0.031	1.00	1.20	1.85	2.80	5.00			20	30	60	100	180
53	REC				0.031			1.85							60		
54																	
55						RVW					Total		total-TIME				
56	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX
57	REF	88309	Level VI - Surgical pathology, gross and microscopic examination		0.031			2.80			90				90		
58	SVY	81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)	15	0.035	1.30	2.35	2.80	2.85	3.50			18	45	80	150	215
59	REC				0.029			2.35							80		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81401 Tracking Number AA2 Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)
CCND1/ IGH (BCL1/ IGH, t[(11;14]d) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative, and quantitative, if performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old asymptomatic man with a family history of Huntington disease presents to his physician for predictive genetic testing for Huntington disease. A sample of anticoagulated peripheral blood is submitted for HTT mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work:

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to PCR amplification for the CACNA1C gene exon which contains the known familial mutation. The PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using capillary electrophoresis. The pathologist evaluates the sequencing electropherograms for the known familial mutation and any other variants that may be present. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81401		
Sample Size: 875	**Resp N:** 59	**Response:** 6.7 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	12.00	50.00	**100.00**	338.00	1500.00
Survey RVW:	0.25	0.40	**0.50**	0.68	1.90
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	22.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81401	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,186,775

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 35.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 81401**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.48
Urgency of medical decision making	3.38	3.43
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.95	4.19
Physical effort required	3.05	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.67
Outcome depends on the skill and judgment of physician	3.95	4.05
Estimated risk of malpractice suit with poor outcome	4.19	4.10

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.86	3.90
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared the physician work of the new code to the key reference code 88291 (Work RVU = 0.52, 20 minutes total time). The expert panel agreed that considering the robust survey results, the median physician time of 15 minutes was typical, and the 25th percentile work RVU of 0.40 appropriately values 81401.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of code 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81400 Tracking Number AA1 Original Specialty Recommended RVU: **0.32**
Presented Recommended RVU: **0.32**
Global Period: XXX RUC Recommended RVU: **0.32**

CPT Descriptor: Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An asymptomatic newborn girl of Northern European descent is suspected to have medium chain acyl dehydrogenase deficiency (MCAD) on the basis of newborn screening. A sample of anticoagulated peripheral blood is submitted for genetic testing for the common ACADM gene K304E variant.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated. The genomic region containing the site of the K304E variant is amplified by PCR using primers that in the presence of the K304E variant, introduce an additional restriction endonuclease site into the amplicon. The PCR products undergo digestion with a restriction endonuclease, and the resulting fragments are separated using gel electrophoresis. The pathologist evaluates the patterns of the digestion fragments in relation to marker and control lanes to determine the patient's mutation and zygosity status. The pathologist composes a report which specifies the patient's mutation and zygosity status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81400		
Sample Size: 875	**Resp N:** 94	**Response:** 10.7 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	88.00	**200.00**	500.00	3000.00
Survey RVW:	0.13	0.32	**0.37**	0.52	1.83
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	7.00	**10.00**	20.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81400	**Recommended Physician Work RVU: 0.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
86320	XXX	0.37	**RUC Time**

CPT Descriptor Immunoelectrophoresis; serum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 41 **% of respondents:** 43.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81400**	**Key Reference CPT Code:** 86320	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**10.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.34	2.98
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.83
Urgency of medical decision making	2.78	2.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.98	2.93
Physical effort required	2.20	2.37
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.41	3.20
Outcome depends on the skill and judgment of physician	2.88	3.15
Estimated risk of malpractice suit with poor outcome	3.73	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	2.68	2.83
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert panel reviewed the survey data and compared the physician work of the new code to the key reference code 86320 (Work RVU = 0.37, 17 minutes total time). The expert panel agreed that considering the robust survey results, the median physician time of 10 minutes was typical, and compared to the key reference service the 25th percentile work RVU of 0.32 appropriately values 81400.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88291

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81402 Tracking Number AA3 Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old girl of Turkish descent is seen by her physician for her third episode of fever accompanied by pleuritic chest pain, abdominal discomfort, and pain in the lower extremity joints. Her physical examination demonstrates a temperature of 38.5°C and dullness to percussion at the left lung base. Her abdomen is rigid with apparent rebound tenderness and diminished bowel sounds, and her left knee is warm and swollen with pain upon passive motion. Her white blood count, erythrocyte sedimentation rate and fibrinogen level are elevated. Familial Mediterranean fever is suspected, and a sample of anticoagulated peripheral blood is submitted for genetic testing for common variants in the MEFV gene.

Percentage of Survey Respondents who found Vignette to be Typical: 66%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to multiplex PCR. Following exonuclease I and shrimp alkaline phosphatase treatment, a second reaction using allele specific primer extension (ASPE) amplifies either the normal or mutant allele sequences for 11 common MEFV variants. The fluorescently-tagged PCR products are separated by capillary electrophoresis. The pathologist evaluates the electropherogram comparing the relative sizes and peak heights of the PCR products to determine mutation and zygosity status. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81402		
Sample Size: 875	**Resp N:** 61	**Response:** 6.9 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	40.00	**90.00**	150.00	1200.00
Survey RVW:	0.25	0.50	**0.52**	0.87	2.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	30.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81402	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	105,397

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

Other Reference CPT Code	Global	Work RVU	Time Source
93924	XXX	0.50	**RUC Time**

CPT Descriptor Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 42.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81402**	**Key Reference CPT Code:** 88291	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.62	3.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.54
Urgency of medical decision making	3.65	3.65
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.88	4.12
Physical effort required	3.12	3.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.62	3.65
Outcome depends on the skill and judgment of physician	3.85	3.92
Estimated risk of malpractice suit with poor outcome	3.69	3.62

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.69	3.77
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The expert panel agreed that the median physician time of 20 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.50 appropriately values 81402.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81403 Tracking Number AA4 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man with chronic myelogenous leukemia (CML) of several years duration on maintenance therapy with imatinib mesylate, experiences a greater than 1 log increase in his BCR/ABL1 transcript levels on repeat measurements. He reports adherence to his therapeutic regimen, and his imatinib level was found to be within the therapeutic range. Because of an apparent loss of response to imatinib, a sample of anticoagulated peripheral blood is submitted for ABL1 tyrosine kinase domain sequencing to assess for imatinib resistance mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality total cellular RNA is isolated and stored under RNase-free conditions. Reverse transcriptase is used to convert RNA to cDNA. PCR amplification using primers for the BCR/ABL1 major breakpoint translocation is performed, followed by nested PCR amplification using internal primers flanking the tyrosine kinase domain region. The nested PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's ABL1 kinase domain mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81403		
Sample Size: 875	**Resp N:** 47	**Response:** 5.3 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	20.00	**30.00**	100.00	400.00
Survey RVW:	0.40	0.52	**0.77**	1.00	2.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**28.00**	35.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81403	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**28.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service?

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Cytogenetics and molecular cytogenetics, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,580,775

CPT Descriptor 1 Visual fieldexamination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	115,072

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 21.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 81403**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	28.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**28.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.70
Urgency of medical decision making	3.50	3.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.90	4.20
Physical effort required	3.30	3.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.10	4.00
Outcome depends on the skill and judgment of physician	3.90	4.20
Estimated risk of malpractice suit with poor outcome	4.10	4.10

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.80	4.00
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81403 was less intense and complex than 88291 however it typically took more time. The overall work effort was therefore similar to 88291. The expert panel agreed that the median physician time of 28 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.52 appropriately values 81403.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81404 Tracking Number AA5 Original Specialty Recommended RVU: **0.65**
Presented Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman who has relatives with head and neck paragangliomas presents to her physician complaining of an enlarging, otherwise asymptomatic right-sided neck mass. Imaging studies suggest a carotid body paraganglioma. The patient is referred to a surgeon, who suspects a hereditary paraganglioma-pheochromocytoma syndrome. An anticoagulated peripheral blood sample is submitted for SDHD gene sequencing.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 4 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81404		
Sample Size: 875	**Resp N:** 49	**Response:** 5.6 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	25.00	**50.00**	100.00	1000.00
Survey RVW:	0.50	0.65	**0.83**	1.15	2.80
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	20.00	**30.00**	45.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81404	**Recommended Physician Work RVU: 0.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88291	XXX	0.52	**RUC Time**

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11200	010	0.82	**RUC Time**	107,711

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 2 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 81404**	**Key Reference CPT Code:** 88291	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.29
Urgency of medical decision making	3.57	3.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.86	3.86
Physical effort required	3.00	2.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.57	3.71
Outcome depends on the skill and judgment of physician	3.86	3.71
Estimated risk of malpractice suit with poor outcome	3.57	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.14	3.57
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291 (Work RVU = 0.52, 20 minutes). The survey respondents indicated code 81404 is greater or as intense and complex as

88291 and it typically takes more time. Therefore, it was clear that there is more overall work in 81404 than in 88291. The expert panel agreed that the median physician time of 30 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.65 appropriately values 81404.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81405 Tracking Number AA6 Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman with a family history that includes several relatives with chromaffin tumors presents to her physician complaining of episodic headaches, palpitations, sweating, and anxiety. Plasma metanephrines are elevated, and an MRI reveals a mass in the region of the organ of Zuckerkandl, that upon resection is confirmed to be a paraganglioma. A hereditary paraganglioma-pheochromocytoma syndrome is suspected, and an anticoagulated peripheral blood sample is submitted for SDHB gene sequencing.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 8 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's SDHB mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81405		
Sample Size: 875	**Resp N:** 31	**Response:** 3.5 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	20.00	**25.00**	50.00	400.00
Survey RVW:	0.52	0.80	**0.94**	1.40	4.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**30.00**	60.00	80.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81405	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88112	XXX	1.18	**RUC Time**

CPT Descriptor Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77003	XXX	0.60	**RUC Time**	1,938,573

CPT Descriptor 1 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92012	XXX	0.92	**RUC Time**	6,568,221

CPT Descriptor 2 92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 16.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 81405**	**Key Reference CPT Code:** 88112	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	43.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**30.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	4.20
Urgency of medical decision making	3.60	3.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.40	4.40
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.20	4.00
Outcome depends on the skill and judgment of physician	4.00	3.80
Estimated risk of malpractice suit with poor outcome	4.40	4.40

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.20	4.00
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88112 (Work RVU = 1.18, 43 minutes). The survey respondents indicated code 81405 is greater, or as intense and complex, as 88112 and it typically takes more time. The expert panel agreed with the survey respondents based on the fact that there are 11-25 exons to be reviewed. The expert panel agreed that the median physician time of 30 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 0.80 appropriately values 81405.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81406 Tracking Number AA7 Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.40**
Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-month-old infant of mixed Ashkenazi Jewish ancestry experiences progressive muscle weakness with a loss of motor skills, decreased attentiveness, and an increased startle response. His pediatrician suspects a diagnosis of Tay-Sachs disease, and the patient is tested for the common Ashkenazi Jewish HEXA gene variants. The patient is found to be heterozygous for the +TATC1278 variant, but no additional common mutations are detected. An anticoagulated peripheral blood sample is submitted for HEXA sequencing to assess the patient for the presence of a second HEXA mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 14 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's HEXA mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81406		
Sample Size: 875	**Resp N:** 27	**Response:** 3.0 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	6.00	**20.00**	40.00	300.00
Survey RVW:	0.70	1.00	**1.40**	1.84	2.80
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	38.00	**60.00**	83.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81406	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88323	XXX	1.83	**RUC Time**

CPT Descriptor Consultation and report on referred material requiring preparation of slides

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92012	XXX	0.92	**RUC Time**	6,568,221

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95819	XXX	1.08	**RUC Time**	303,721

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 25.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 81406**	**Key Reference CPT Code:** 88323	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	56.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**56.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.57	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	4.43
Urgency of medical decision making	3.57	3.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.71	4.71
Physical effort required	4.57	4.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.43	4.14
Outcome depends on the skill and judgment of physician	4.86	4.71
Estimated risk of malpractice suit with poor outcome	4.71	4.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	5.00	4.86
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88323 (Work RVU = 1.83, 56 minutes). The survey respondents indicated code 81406 is greater, or as intense and complex, as 88323 and it typically takes more time. All intensity and complexity measures indicated a high intensity and complexity. The expert panel agreed with the survey respondents based on the fact that there are 26-50 exons to be reviewed. The expert panel agreed that the median physician time of 60 minutes is typical and compared to the key reference service, the median work RVU of 1.40 appropriately values 81406.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81407 Tracking Number AA8 Original Specialty Recommended RVU: **1.85**
Presented Recommended RVU: **1.85**
Global Period: XXX RUC Recommended RVU: **1.85**

CPT Descriptor: Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-month-old girl with a family history of epilepsy is taken to her pediatrician after experiencing a febrile seizure in association with a viral infection. An SCN1A-related seizure disorder is suspected. An anticoagulated peripheral blood sample is submitted for SCN1A sequencing to assess the patient for the presence of a SCN1A-related seizure disorder mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 30 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's SCN1A mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD					
Specialty(s):	College of American Pathologists and American College of Medical Genetics					
CPT Code:	81407					
Sample Size:	875	**Resp N:**	15	**Response:** 1.7 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	10.00	**20.00**	31.00	750.00
Survey RVW:	1.00	1.20	**1.85**	2.80	5.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	30.00	**60.00**	100.00	180.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81407	**Recommended Physician Work RVU: 1.85**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88309	XXX	2.80	**RUC Time**

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94002	XXX	1.99	**RUC Time**	17,741

CPT Descriptor 1 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11640	XXX	1.67	**RUC Time**	16,140

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
88323	XXX	1.83	**RUC Time**

CPT Descriptor Consultation and report on referred material requiring preparation of slides

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 81407**	**Key Reference CPT Code:** 88309	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**60.00**	**90.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.67	4.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	4.67
Urgency of medical decision making	4.33	4.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.83	5.00
Physical effort required	4.33	4.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	5.00	5.00
Estimated risk of malpractice suit with poor outcome	4.83	4.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.83	4.50
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88309 (Work RVU = 2.80, 90 minutes). The survey respondents indicated code 81407 is greater, or as intense and complex as 88309 in 5 out of 9 measures. All intensity and complexity measures indicated a high intensity and complexity. The expert panel agreed with the survey respondents that 81407 is complex and intense. The expert panel agreed that the median physician time of 60 minutes is typical and compared to the key reference service, the median work RVU of 1.85 appropriately values 81407 within this family of Tier 2 services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:81408 Tracking Number AA9 Original Specialty Recommended RVU: **2.35**
Presented Recommended RVU: **2.35**
Global Period: XXX RUC Recommended RVU: **2.35**

CPT Descriptor: Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-month-old girl is found by her pediatrician to have mild axillary freckling and 2 large café-au-lait macules on routine physical examination. The history and physical examination is otherwise within normal limits. A diagnosis of neurofibromatosis is suspected. An anticoagulated peripheral blood sample is submitted for NF1 sequencing to assess the patient for the presence of a neurofibromatosis-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 58 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The pathologist evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The pathologist compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The pathologist composes a report specifying the patient's NF1 mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2011		
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP, Aaron D. Bossler, MD, PhD, and Thomas M. Williams, MD		
Specialty(s):	College of American Pathologists and American College of Medical Genetics		
CPT Code:	81408		
Sample Size: 875	**Resp N:** 15	**Response:** 1.7 %	
Sample Type: Convenience	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	10.00	**18.00**	25.00	300.00
Survey RVW:	1.30	2.35	**2.80**	2.85	3.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	18.00	45.00	**80.00**	150.00	215.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	81408	**Recommended Physician Work RVU: 2.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**80.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88309	XXX	2.80	**RUC Time**

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11424	010	2.48	**RUC Time**	5,832

CPT Descriptor 1 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99253	XXX	2.27	**RUC Time**	3,265,358

CPT Descriptor 2 Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
88189	XXX	2.23	**RUC Time**

CPT Descriptor Flow cytometry, interpretation; 16 or more markers

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 66.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 81408**	**Key Reference CPT Code:** 88309	**Source of Time** RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	80.00	90.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**80.00**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.30	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.00
Urgency of medical decision making	4.00	4.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.70	4.50
Physical effort required	3.90	3.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	4.50
Outcome depends on the skill and judgment of physician	4.60	4.50
Estimated risk of malpractice suit with poor outcome	4.10	4.10

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.70	4.40
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88309 (Work RVU = 2.80, 90 minutes). The survey respondents indicated code 81408 is greater, or as intense and complex as 88309 in 8 out of 9 measures. All intensity and complexity measures indicated a high intensity and complexity. The expert panel agreed with the survey respondents that 81408 is complex and intense. The expert panel agreed that the median physician time of 80 minutes is typical and compared to the key reference service, the 25th percentile work RVU of 2.35 appropriately values 81408 within this family of Tier 2 services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty College of American Pathologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88182

AMA
AMERICAN MEDICAL ASSOCIATION

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org
312.464.5000

May 26, 2012

Jonathan Blum
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: HCPAC Recommendations

Dear Mr. Blum:

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board submits the enclosed recommendation to the Centers for Medicare and Medicaid Services (CMS). The HCPAC reviewed CPT code 90863 *Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services* identified through the Fourth Five-Year Review process, at its April 26, 2012 meeting.

The RUC and HCPAC are fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values. The HCPAC appreciates the opportunity to provide recommendations related to the 2013 Medicare Physician Payment Schedule. If you have any questions regarding this submission, please contact Susan Clark via (202) 789-7495 or Susan.Clark@ama-assn.org at the AMA for clarification regarding these recommendations.

Sincerely,

Arthur Traugott, MD
HCPAC Chair

Anthony Hamm, DC
HCPAC Co-Chair

cc: HCPAC Participants
Edith Hambrick, MD
Ryan Howe
Christina Ritter
Sara Vitolo

Attachments

Health Care Professionals Advisory Committee (HCPAC) Summary of Recommendations
Fourth Five-Year Review

April 2012

Pharmacologic Management with Psychotherapy

In February 2012, as part of the new psychotherapy coding framework, the CPT Editorial Panel created code 90863 *Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)* to allow psychologists who perform pharmacologic management services for their patients as an add-on to psychotherapy to report these services.

The American Psychological Association recommended that code 90863 be carrier priced as this service is being reported by approximately 100 individuals in two states and it would be difficult to survey at this time. **The HCPAC agreed and recommends that CPT code 90863 be carrier priced.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Psychiatry				
Psychiatry services include diagnostic services, psychotherapy, and other services to an individual, family, or group. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. Services may be provided to a patient in crisis. Services are provided in all settings of care and psychiatry services codes are reported without regard to setting. Services may be provided by a physician or other qualified health care professional. Some psychiatry services may be reported with **Evaluation and Management Services** (99201-99255, 99281-99285, 99304-99337, 99341-99350) or other services when performed. **Evaluation and Management Services** (99201-99285, 99304-99337, 99341-99350) may be reported for treatment of psychiatric conditions, rather than using **Psychiatry Services** codes, when appropriate.				

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Hospital care ~~by the attending physician~~ in treating a psychiatric inpatient or partial hospitalization may be initial or subsequent in nature (see 99221-99233)~~ and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations~~.

Some patients receive hospital evaluation and management services only and others receive hospital evaluation and management services and other procedures. If other procedures such as electroconvulsive therapy or psychotherapy are rendered in addition to hospital evaluation and management services, these ~~should~~may be listed separately (~~ie~~eg, hospital care services (99221-99223, 99231-99233) plus electroconvulsive therapy (90870), or when psychotherapy is done, ~~an~~with appropriate code(s) defining psychotherapy ~~with medical evaluation and management~~ services~~). Modifier 22 may be used to indicate a more extensive service. Modifier 52 may be used to signify a service that is reduced or less extensive than the usual procedure~~.

~~Other evaluation and management services, such as office medical service or other patient encounters, may be described as listed in the section on **Evaluation and Management,** if appropriate.~~

~~The evaluation and management services should not be reported separately, when reporting codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829.~~

Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with the primary physician and other informants such as nurses or family members, and preparation of a report. These ~~consultation~~ services ~~(99241-99255) are limited to initial evaluation and do not involve psychiatric treatment. Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient are~~may be reported using ~~the appropriate codes for established patients, office visits (99211-99215), domiciliary, rest home (99334-99337), or home (99347-99350). If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office~~ consultation codes ~~may be used again. Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem~~see **Consultations**~~) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services~~.

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Interactive Complexity

Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care.

These factors are typically present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Psychiatric procedures may be reported "with interactive complexity" when at least one of the following is present:

1. The need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.

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3. Evidence or disclosure of a sentinel event and mandated report to third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, other physical devices, interpreter or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who:

- Is not fluent in the same language as the physician or other qualified health care professional, or
- Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

When provided in conjunction with the psychotherapy codes 90832-90838, the amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350) and must relate to the psychotherapy service only. Interactive complexity is not a factor for Evaluation and Management Services selection (99201-99255, 99281-99285, 99304-99337, 99341-99350), except as it directly affects key components as defined in Evaluation and Management Services Guidelines (ie, history, examination and medical decision making).

+●90785	LL1	Interactive Complexity (List separately in addition to the code for primary procedure) (Use 90785 is conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853)) (Do not use 90785 in conjunction with 90839, 90840 or in conjunction with E/M services when no psychotherapy service is also reported)	ZZZ	Carrier Price (RUC Recommendation)

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Psychiatric Diagnostic ~~or Evaluative Interview~~ Procedures

Psychiatric diagnostic ~~interview examination includes a~~evaluation is an integrated biopsychosocial assessment, including history, mental status, and ~~a disposition, and~~recommendations. The evaluation may include communication with family or other sources~~, ordering~~ and review and ~~medical interpretation~~ordering of ~~laboratory or other medical~~ diagnostic studies~~. In certain circumstances other informants will be seen in lieu of the patient~~.

Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances. Codes 90791, 90792 may be reported once per day and not on the same day as an Evaluation and Management service performed by the same individual for the same patient.

~~Interactive psychiatric diagnostic interview examination is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.~~

The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure. These services should be reported with add-on code 90785 used in conjunction with the diagnostic psychiatric evaluation codes 90791, 90792.

Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day.

D90801		~~Psychiatric diagnostic interview examination~~	XXX	N/A

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D90802		~~Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication~~ (90801 and 90802 have been deleted. To report diagnostic evaluations, see 90791, 90792)	XXX	N/A
●90791	LL2	Psychiatric diagnostic evaluation	XXX	3.00 (RUC Recommendation)
●90792	LL3	Psychiatric diagnostic evaluation with medical services (Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444) (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)	XXX	3.25 (RUC Recommendation)

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Psychiatric Therapeutic Procedures

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy; and Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy.
Interactive psychotherapy is typically furnished to children. It involves the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Some patients receive psychotherapy only and others receive psychotherapy and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (eg, evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.

In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive using non-verbal techniques versus insight oriented, behavior modifying and/or supportive using verbal techniques), the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy. Face-to-face time when providing psychotherapy with medical evaluation and management services includes time spent providing both psychotherapy and evaluation and management services (ie, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).
To report medical evaluation and management services furnished on a day when psychotherapy is not provided, select the appropriate code from the **Evaluation and Management Services Guidelines.**

Office or Other Outpatient Facility Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy

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D90804		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A
D90805		~~with medical evaluation and management services~~	XXX	N/A
D90806		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A
D90807		~~with medical evaluation and management services~~	XXX	N/A
D90808		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90809		~~with medical evaluation and management services~~ (90804, 90805, 90806, 90807, 90808, 90809 have been deleted. To report, see 90832, 90833, 90834, 90836, 90837, 90838 and 99201-99215, 99217-99220, 99224-99226, 99234-99236 as appropriate)	XXX	N/A
D90810		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A

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D90811		~~with medical evaluation and management services~~	XXX	N/A
D90812		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A
D90813		~~with medical evaluation and management services~~	XXX	N/A
D90814		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90815		~~with medical evaluation and management services~~ (90810, 90811, 90812, 90813, 90814, 90815 have been deleted. To report, use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 and 99201-99215, 99217-99220, 99224-99226, 99234-99236 as appropriate)	XXX	N/A
D90816		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A
D90817		~~with medical evaluation and management services~~	XXX	N/A

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D90818		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A
D90819		~~with medical evaluation and management services~~	XXX	N/A
D90821		~~Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90822		~~with medical evaluation and management services~~ (90816, 90817, 90818, 90819, 90821, 90822 have been deleted. To report, see 90832, 90833, 90834, 90836, 90837, 90838 and 99221-99223, 99231-99233, 99304-99316, 99324-99337 as appropriate)	XXX	N/A
D90823		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;~~	XXX	N/A
D90824		~~with medical evaluation and management services~~	XXX	N/A
D90826		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;~~	XXX	N/A

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D90827		~~with medical evaluation and management services~~	XXX	N/A
D90828		~~Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;~~	XXX	N/A
D90829		~~with medical evaluation and management services~~ (90823, 90824, 90826, 90827, 90828, 90829 have been deleted. To report, use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 and 99221-99223, 99231-99233, 99304-99316, 99324-99337 as appropriate)	XXX	N/A

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Psychotherapy

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

The psychotherapy service codes 90832–90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process.

Psychotherapy times are for face-to-face services with patient and/or family member. The patient must be present for all or some of the service. For family psychotherapy without the patient present, use 90846. In reporting, choose the code closest to the actual time (ie, 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. (See instructions for the usage of Time in the Introduction of the CPT code set).

Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to the psychotherapy codes 90832-90838. For psychotherapy for crisis, see "Other Psychotherapy".

Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an Evaluation and Management service (90833, 90836, 90838).

Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with Evaluation and Management services (90833, 90836, and 90838) as add-on codes to the Evaluation and Management service.

Medical symptoms and disorders inform treatment choices of psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows:

1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making.

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a. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (ie, time spent on history, examination and medical decision making **when used for the E/M service** is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported. b. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.				
●90832	LL4	Psychotherapy, 30 minutes with patient and/or family member	XXX	1.50 (RUC Recommendation)
●+90833	LL5	Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure) (Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)	ZZZ	1.50 (RUC Recommendation)
●90834	LL6	Psychotherapy, **45** minutes with patient and/or family member	XXX	2.00 (RUC Recommendation)
●+90836	LL7	Psychotherapy, **45** minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure) (Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350)	ZZZ	1.90 (RUC Recommendation)
●90837	LL8	Psychotherapy, **60** minutes with patient and/or family member	XXX	3.00 (RUC Recommendation)

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●+90838	LL9	Psychotherapy, **60** minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure) (Use 90838 in conjunction with 99201-99255, 99304-99337, 99341-99350) (Use the appropriate prolonged services code (99354-99357) for psychotherapy services 68 minutes or longer) (Use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)	ZZZ	2.50 (RUC Recommendation)

Other Psychotherapy
Psychotherapy for Crisis

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791 or 90792.

Code 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other health care professional is not continuous on that date. Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with 90832 or 90833 (when provided with Evaluation and Management services).

(90840 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes)

●90839	LL10	Psychotherapy for crisis, first 60 minutes;	XXX	Carrier Price (RUC Recommendation)

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+●90840	LL11	each additional 30 minutes (List separately in addition to code for primary service) (Use 9080CP2 in conjunction with 9080CP1) (Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)	ZZZ	Carrier Price (RUC Recommendation)
90845	LL12	Psychoanalysis	XXX	2.10 (RUC Recommendation October 2011)
90846	LL13	Family psychotherapy (without the patient present)	XXX	2.40 (RUC Recommendation)
90847	LL14	Family psychotherapy (conjoint psychotherapy) (with patient present)	XXX	2.50 (RUC Recommendation)
90849		Multiple-family group psychotherapy	XXX	0.59 (No Change)
90853	LL15	Group psychotherapy (other than of a multiple-family group) (Use 90785 in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)	XXX	0.59 (No Change)
D90857		~~Interactive group psychotherapy~~ (90857 has been deleted. To report, use 90785 in conjunction with 90853)	XXX	N/A

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Other Psychiatric Services or Procedures (For repetitive transcranial magnetic stimulation for treatment of clinical depression, see Category III codes 0160T, 0161T) (For analysis/programming of neurostimulators used for vagus nerve stimulation therapy, see 95970, 95974, 95975)				
D90862		~~Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy~~ (90862 has been deleted. To report see evaluation and management codes 99201-99255, 99304-99337, 99341-99350 or 90863)	XXX	N/A
●+90863	LL16	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) (Use 90863 in conjunction with 90832, 90834, 90837) (For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional, who may report Evaluation and Management codes, use the appropriate Evaluation and Management codes 99201-99255, 99281-99285, 99304-99337, 99341-99350 and the appropriate Psychotherapy with Evaluation and Management service 90833, 90836, 90838) (Do not count time spent on providing pharmacologic management services in the time used for selection of the psychotherapy service)	ZZZ	Carrier Price (HCPAC Recommendation)
90875		Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the Patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); ~~approximately 20~~ 30 minutes		
90876		~~approximately~~ 45~~-50~~ minutes		

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Practice Expense Subcommittee
Staff Note

Migration of Radiologic Images from Film to Digital Workgroup

In September 2011, the American College of Radiology (ACR) agreed to continue to collect data and review the typical Picture Archiving and Communication Systems (PACS) environment across specialty. The specialty requested the AMA's assistance in collecting additional data on this topic. A survey was developed collaboratively and deployed by the AMA in December 2011. The survey was sent to over 100,000 practicing patient care AMA physician members with an n=700. The report focuses on the top 7 specialties with 30 or more respondents. The survey results indicate that PACS ownership is now or soon will be typical in 6 of the top 7 specialties. Obstetrics and Gynecology is the only specialty where PACS is not yet typical.

Given this more robust data, indicating that PACS are typical, the ACR agreed to propose a timeline/workplan to develop appropriate practice expense inputs for PACS to replace practice expense inputs related to film for the appropriate codes. The ACR will provide a verbal update at the April meeting. The Practice Expense Subcommittee should discuss next steps, including the establishment of a workgroup, to address this concern. The workgroup should include representation from ACR and other appropriate specialty societies.

The workgroup will be charged with the following tasks:

- Develop appropriate practice expense inputs for PACS to replace practice expense inputs related to film for the appropriate codes.
- Identify which codes are appropriate to be migrated from film to PACS
- Reevaluate the need for a laser printer for all codes that will transition to reporting PACS rather than film.
- Reevaluate the need for equipment codes SK030, SK058, SK065 once the transition from film to digital is complete. These inputs are not part of the PACS system, but should be considered by the workgroup as related equipment.

Practice Expense Subcommittee
Staff Note

Migration of Radiologic Images from Film to Digital Workgroup

In April 2011, the American College of Radiology provided the PE Subcommittee with an update on their work in evaluating the migration of film acquisition to Picture Archiving and Communication Systems (PACS) through an internal ACR Workgroup. To further their evaluation, the ACR provided the PE Subcommittee with survey results from a survey conducted to determine the typical usage of PACS. The survey received 64 respondents from the AAOS, 15 respondents from the ACC and 3 respondents from the ACP. Of the 82 total respondents, 84% stated that they use PACS. The specialty also provided the typical scenario per modality. For CT, MR and interventional the use of PACS are typical. For x-ray and ultrasound PACS are not currently typical. The specialty noted, that while radiologists were not surveyed, the ACR confirmed that the above typical scenarios are accurate for the radiology community as well. The specialty and the Workgroup agreed that the ACR should continue to collect data and review the typical PACS environment across specialty and report back to the PE Subcommittee in February 2012. Staff also noted that the AMA could provide assistance to survey physicians about current PACS usage. AMA staff will work with the ACR regarding additional data collection.

PACS Survey

The AMA and the ACR worked together to collect additional data on this topic. A survey was developed collaboratively and deployed by the AMA in December, 2011. The survey was sent out on December 12th to all practicing patient care physicians on AMA's email opt-in list (118,139 physicians). The survey closed on December 20th. The subject line of the email was designed to encourage participation from physicians most likely to be interested in imaging systems (Use of Imaging Across Medicine). 1,498 physicians accessed the survey and 62% of those who accessed the survey perform and/or review/interpret imaging services (n=934). The results of the survey are included in the attached table entitled *PACS Survey Results*. Based on physicians self-reporting of their primary practice in Q9, the hospital based physicians (n=234) have been filtered out resulting in a new total of n=700. The report focuses on the top 7 specialties with 30 or more respondents. The survey results indicate that PACS ownership is now or soon will be typical in 6 of the top 7 specialties. Obstetrics and Gynecology is the only specialty with 30 or more respondents where PACS is not yet typical. Family Medicine reported 46% currently own PACS, however if you consider those that plan to obtain PACS within 2012 it puts the specialty to nearly 60%. The results of the survey have been shared with ACR for further comment by the January 26 PE Subcommittee meeting.

PACS Survey Results

		Total		Cardiology		Family Medicine		Internal Medicine		Obstetrics and Gynecology		Orthopaedic Surgery		Radiology		Urology	
		N	N%	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%
Q1 Does your practice perform and/or review/interpret imaging services? (Please Select all that Apply)	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	Yes	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	No	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%
Q2 For which modalities does your practice perform and/or review/interpret imaging services?	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	X-ray	465	66.4%	9	17.3%	76	88.4%	33	84.6%	8	14.3%	49	96.1%	74	96.1%	21	51.2%
	Ultrasound	462	66.0%	44	84.6%	35	40.7%	27	69.2%	55	98.2%	12	23.5%	76	98.7%	37	90.2%
	CT	327	46.7%	19	36.5%	22	25.6%	22	56.4%	2	3.6%	16	31.4%	72	93.5%	19	46.3%
	MRI	277	39.6%	6	11.5%	19	22.1%	16	41.0%	2	3.6%	28	54.9%	73	94.8%	5	12.2%
	Nuclear Medicine	206	29.4%	42	80.8%	10	11.6%	15	38.5%	1	1.8%	4	7.8%	67	87.0%	6	14.6%
	Interventional Radiology	141	20.1%	6	11.5%	5	5.8%	9	23.1%	1	1.8%	0	.0%	60	77.9%	6	14.6%
	PET/CT	134	19.1%	6	11.5%	6	7.0%	10	25.6%	1	1.8%	1	2.0%	58	75.3%	2	4.9%
Q3 Does your practice own PACS (Picture Archiving and Communication System)?	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	Yes	374	53.4%	27	51.9%	40	46.5%	24	61.5%	20	35.7%	34	66.7%	63	81.8%	21	51.2%
	No	326	46.6%	25	48.1%	46	53.5%	15	38.5%	36	64.3%	17	33.3%	14	18.2%	20	48.8%

PACS Survey Results

		Total		Cardiology		Family Medicine		Internal Medicine		Obstetrics and Gynecology		Orthopaedic Surgery		Radiology		Urology	
		N	N%	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%
Q4 If not own, does your practice use PACS (Picture Archiving and Communication System)?	Total	326	100.0%	25	100.0%	46	100.0%	15	100.0%	36	100.0%	17	100.0%	14	100.0%	20	100.0%
	Yes	124	38.0%	7	28.0%	9	19.6%	3	20.0%	8	22.2%	7	41.2%	13	92.9%	9	45.0%
	No	202	62.0%	18	72.0%	37	80.4%	12	80.0%	28	77.8%	10	58.8%	1	7.1%	11	55.0%
Q5 For which modalities do you use PACS? (Please select all that apply)	Total	498	100.0%	34	100.0%	49	100.0%	27	100.0%	28	100.0%	41	100.0%	76	100.0%	30	100.0%
	X-ray	387	77.7%	15	44.1%	47	95.9%	25	92.6%	6	21.4%	41	100.0%	73	96.1%	16	53.3%
	Ultrasound	309	62.0%	27	79.4%	23	46.9%	23	85.2%	26	92.9%	9	22.0%	74	97.4%	18	60.0%
	CT	339	68.1%	17	50.0%	28	57.1%	22	81.5%	5	17.9%	18	43.9%	70	92.1%	25	83.3%
	MRI	303	60.8%	14	41.2%	25	51.0%	17	63.0%	4	14.3%	28	68.3%	72	94.7%	15	50.0%
	Nuclear Medicine	203	40.8%	25	73.5%	7	14.3%	13	48.1%	1	3.6%	7	17.1%	68	89.5%	12	40.0%
	Interventional Radiology	151	30.3%	9	26.5%	3	6.1%	6	22.2%	1	3.6%	4	9.8%	62	81.6%	8	26.7%
	PET/CT	167	33.5%	10	29.4%	5	10.2%	11	40.7%	1	3.6%	4	9.8%	60	78.9%	6	20.0%
Q6 What brand(s) of PACS is used in your practice?	Total	498	100.0%	34	100.0%	49	100.0%	27	100.0%	28	100.0%	41	100.0%	76	100.0%	30	100.0%
	GE Healtcare	141	28.3%	11	32.4%	13	26.5%	9	33.3%	12	42.9%	10	24.4%	26	34.2%	4	13.3%
	Phillips	86	17.3%	10	29.4%	6	12.2%	5	18.5%	3	10.7%	7	17.1%	18	23.7%	5	16.7%
	McKesson	82	16.5%	7	20.6%	8	16.3%	3	11.1%	2	7.1%	6	14.6%	12	15.8%	6	20.0%
	Siemens	55	11.0%	4	11.8%	3	6.1%	4	14.8%	3	10.7%	4	9.8%	5	6.6%	3	10.0%
	FUJIFILM	31	6.2%	3	8.8%	2	4.1%	2	7.4%	0	.0%	2	4.9%	13	17.1%	1	3.3%
Q7 If not own, when does your practice plan to obtain PACS (Picture Archiving and Communication System)?	Total	326	100.0%	25	100.0%	46	100.0%	15	100.0%	36	100.0%	17	100.0%	14	100.0%	20	100.0%
	1-3 months from now	10	3.1%	0	.0%	2	4.3%	1	6.7%	0	.0%	1	5.9%	2	14.3%	1	5.0%
	4-6 months from now	13	4.0%	2	8.0%	2	4.3%	1	6.7%	2	5.6%	1	5.9%	0	.0%	0	.0%
	7-12 months from now	13	4.0%	1	4.0%	2	4.3%	2	13.3%	0	.0%	2	11.8%	0	.0%	0	.0%
	More than a year from now	21	6.4%	1	4.0%	2	4.3%	1	6.7%	4	11.1%	1	5.9%	0	.0%	0	.0%

PACS Survey Results

		Total		Cardiology		Family Medicine		Internal Medicine		Obstetrics and Gynecology		Orthopaedic Surgery		Radiology		Urology	
		N	N%	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%
	No plans to obtain	269	82.5%	21	84.0%	38	82.6%	10	66.7%	30	83.3%	12	70.6%	12	85.7%	19	95.0%
Q8 Please indicate which of the following best describes your medical specialty.	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
Q9 What is your primary practice type?	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	Solo practice	123	17.6%	12	23.1%	15	17.4%	6	15.4%	14	25.0%	10	19.6%	3	3.9%	5	12.2%
	Single specialty group	336	48.0%	27	51.9%	31	36.0%	10	25.6%	29	51.8%	31	60.8%	55	71.4%	22	53.7%
	Multiple-specialty group	216	30.9%	12	23.1%	37	43.0%	19	48.7%	12	21.4%	9	17.6%	14	18.2%	12	29.3%
	Hospital based	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%
	Other (specify)	25	3.6%	1	1.9%	3	3.5%	4	10.3%	1	1.8%	1	2.0%	5	6.5%	2	4.9%
Q10 Is your practice physician owned?	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	Yes	516	73.7%	40	76.9%	54	62.8%	26	66.7%	36	64.3%	43	84.3%	63	81.8%	32	78.0%
	No	184	26.3%	12	23.1%	32	37.2%	13	33.3%	20	35.7%	8	15.7%	14	18.2%	9	22.0%
Q11 How would you describe the area in which your practice is located?	Total	700	100.0%	52	100.0%	86	100.0%	39	100.0%	56	100.0%	51	100.0%	77	100.0%	41	100.0%
	Urban	281	40.1%	23	44.2%	21	24.4%	20	51.3%	19	33.9%	22	43.1%	40	51.9%	17	41.5%
	Suburban	305	43.6%	22	42.3%	39	45.3%	12	30.8%	31	55.4%	21	41.2%	26	33.8%	18	43.9%
	Rural	114	16.3%	7	13.5%	26	30.2%	7	17.9%	6	10.7%	8	15.7%	11	14.3%	6	14.6%

Practice Expense Subcommittee
Staff Note

Endoscope Cleaning and Disinfecting Pack, SA042

In January 2012, the PE Subcommittee noted that the pack included in supplies for cleaning the endoscope, CMS supply item SA042, includes gluteraldehyde (disinfecting/sanitizing agent) and does not contain a basin for the glueraldehyde. American Society for Gastrointestinal Endoscopy recommends that the irrigation basin, CMS code SJ009, be added to the pack below.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning and disinfecting, endoscope	**SA042**	**pack**		**15.520**
gloves, non-sterile		pair	4	0.084
gown, staff, impervious		item	1	1.186
face shield, splash protection		item	1	1.706
biohazard bag		item	1	0.062
gauze, sterile 4in x 4in (10 pack uou)		item	1	0.798
alcohol isopropyl 70%		ml	60	0.002
cleaning brush, endoscope		item	1	4.992
glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)		oz	32	0.165
glutaraldehyde test strips (Cidex, Metrex)		item	1	1.012